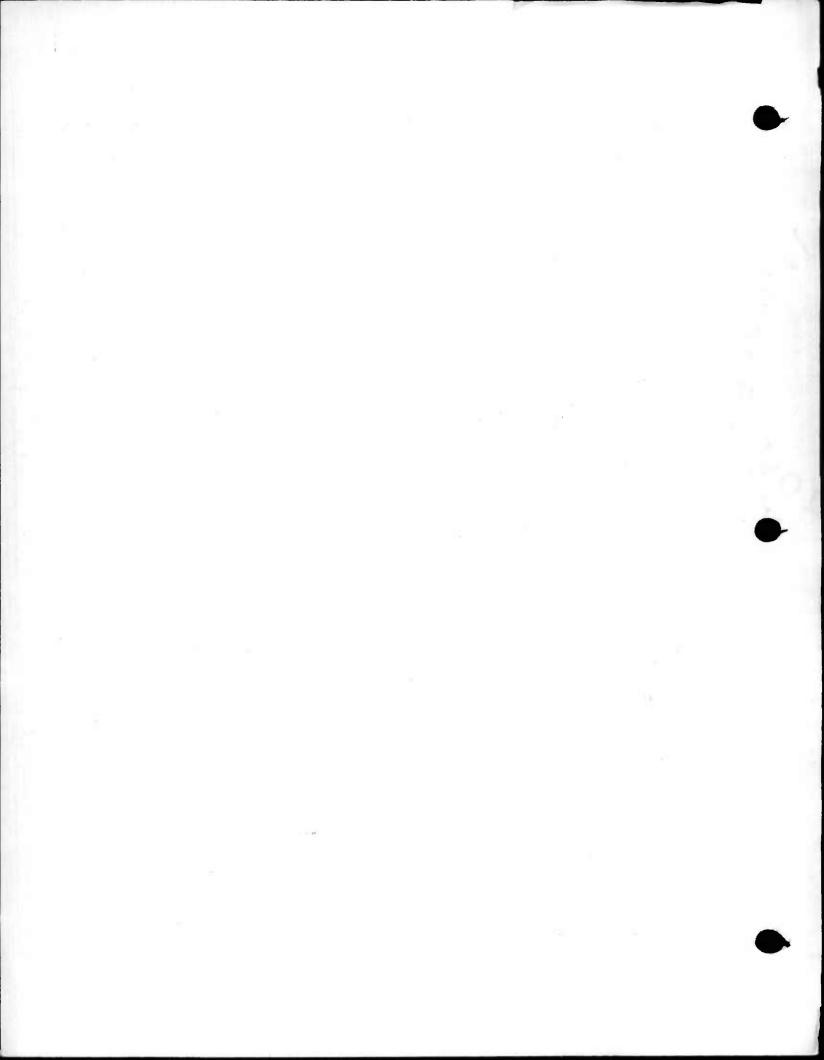
6

31. DATE FILED (Month, Day, Year)
APR 24 1995

32. BEGISTRAR'S SIGNATURE
Julia Dauxlaux Rardall

	State	requires that the death certificate
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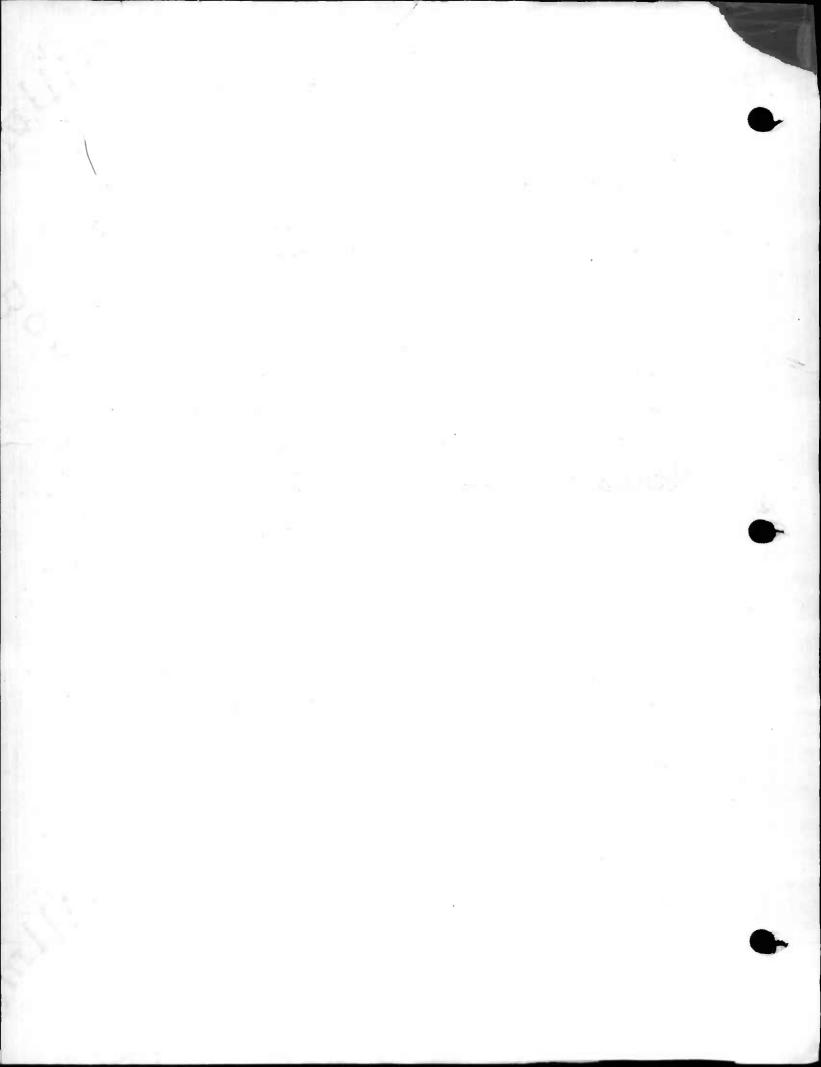
												95		37) U I
	FOR STATE REGISTRAR		STATE OF I	MARYLAND C	DEPAR					MENTAL	HYGIENI REG. NO.	E			
1	1. DECEDENT'S NAME (First, M.	liddle, Last)									OF DEATH			3. TIM	E OF DEATH
	MARTON	Este	elle		ELLIC	ידידע				MONTH DAY YEAR APRIL 21, 1995				00	-00 M
	4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In yrs. last birthday) IF UNDE				N 1 YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH	190			State or Foreign
- 3	218 56 3598	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	400	Countr	MD MD				
3	9e. FACILITY NAME (If not institu	rution, give sti	reet and number)			9b, CIT	Y, TOWN (R LOCATIO	ON OF DI	Jan.	-34-	1909	NTY OF D	EATH	
K	CALVERT MEMO			PR.	INCE	FRED	ERT	CK			VERT				
ਹੋ	RESIDENCE OF DECE	DENT											_		
DIRECTOR		Ob. COUNTY					OR LOCAT							10d. th	ISIDE CITY MITS?
	MD	Calv	ert		Br	COOM	e's :	Slar	nd					1 🗆 Y	res 200 NO
FUNERAL	10e. STREET AND NUMBER	_						ZIP CODE				10g. CIT	ZEN OF W	VHAT CO	DUNTRY?
ÿ	8835 Broome's	s Isl						20615)			US	SA		
5	11. MARITAL STATUS 1 Never Married 2 Ma	inted	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13.	WAS DEC	ENDENT O	F HISPAN	NIC ORIGIN?	(Specify Yee	or No-	14. RACE Black	- Ame	erican Indien, etc.
ВҰ	3 Widowed 4 Divorce		IF YES, GIVE V		•			2 NO			, , , , ,		Specif	ity:	
8		ENT'S EDUC	ATION	140.0	ECEDENT'S	1101111 0	00110471			T				Wn	ite
	(Specify only hi	ighest grade (completed)	(0	Give kind of a B. Do NOT us	work done	during mo	st of workin	g	160.	KIND OF BUS	INESS/IN	JUSTRY		
7	Elementary/Secondary (0-12	"	College (1-4 or 5	/	Waitr					- 1 -	Restau	ırant	-		
COMPLET	17. FATHER'S NAME (First, Middle	Ve. Last)						16 MOTE	JED'C NA		iddle, Meiden S				
Ш О			Mister						ilda		ddie, welden s	sumame)		Sui	to
00	19e. INFORMANT'S NAME (Type										or City or Town	Chata 7is		Dui	ce
인				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								20645			
	Brice I. Flliott 8841 Broome's Island Rd., Broome's Is., MD 20615 200. METHOD OF DISPOSITION 200. PLACE AND DATE 00. LOCATION — City or Town, State														
	12 Buriat 2 Cremation 4 Donation 5 Other (Sc	3 🗌 Ramo	val from State	cemetery or	emetory or o	ther place	1			1			•		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE April 24 Donation 5 Other (Specify) Broome's Is., MD 22. NAME AND ADDRESS OF FACILITY														
	11/11/	7/	1 PM			Ъ.	nucak	. Enam	OF0.	l Hom	o Dor	+ Da	hubl	lia	2 0676
	100 - 1110	de	119	970		11/6	ausch Funeral Home, Port Republic, MD or the mode of dying, such as cerdiec or respiratory arrest, Approximate								
	23. PART i. Enter the dise shock, or hear	eses, Dr ci rt fsiiure. L	omplicetions that list only one csu	caused the d	eeth. Do r	not ante	r the mo	de of dyi	ng, suc	h ss cerdi	ec or reepir	atory sn	rest,		pproximate ntervai Between
	IMMEDIATE CAUSE (Final														nset and Death
	disease or condition resulting in desth)	- a		eps,	5									43	3 Days
	77		DUE TO	(OR AS A CONSE	OUENCE O	F):		_							
S	Sequentielly list condition	s. 6													
CERTIFICATION	if sny, lesding to immedia	te	DUE TO	(OR AS A CONSE	OUENCE O	F):								1	
윤	CAUSE (Diseese or injury		DUE TO	OR AS A CONSE	OLIENCE O	D.									
E	thet initieted events resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF):											i	
B		d												+	
A	PART ii. Other significent	conditions	contributing to	death but not	resulting	in the u	ndarlying	cause g	iven in	Part i.	24a. WAS AN		24b.		UTOPSY FINDINGS
20	(YLRY	rec,	MA	mon	-/-	4	10/		7.		PERFORI	NO		COMPLI	BLE PRIOR TO ETION DF CAUSE
Ä	Card	120	e (4)	why,	Ahn	~	2			_		-4.0		OF DEA	TH7 ES 2 NO
-	DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF DEA	ATH YE	S 🗆	NO [UNC	ERTAIN	νП					
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO M				CE OF DEAT	TH (Check	only one)								
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient	DOA	OTHE		5 🗆 Re	sidence	6 🗆 Other	(Specify)				
	27. MANNER OF DEATH		28e. DATE OF		28b. TIM	E OF	28c. INJ	JRY AT			RIBE HOW IN	JURY OC	CURED		
BY	1 Netural 5 Pen 2 Accident Inve	nding estigation	(Month, D	iy, reary	l las	URY M	1 🗌 Y	ES 2] NO						
- 4	3 Sudalda —	uld not be	28e. PLACE O	F INJURY — At h	ome, farm, s	street, tac	tory, office	,			TION (Street or	nd Number	or Rural R	loute Nui	mber,
111		ermined	Duttuing,	etc. (Specify)						City or	Town, State)				
7	29a. CERTIFIER 1 CERTIFY	ING PHYSIC	IAN: To the beat of	my knowledge de	eath occum	ed at the	time, date	and place	and due	to the cours	a(a) and ma-	ner en el	ad		
COMPLETED			On the basis of ea											and m	inner se stated
	29b. SIGNATURE AND TITLE OF						-				1				
8	N. P	6/	als.	M.D				29c. LICE			11		E SIGNED		
2	30 NAME AND ADDRESS OF PE	ERSON WHO	COMPLETED CAUS		<u>.</u>	Delast		-	-	-00	4	4	- 4	/ /	-3



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA	ATH DAY	WEAR	3. TIME OF DEATH		
	Barbara	Allen Ear	rnest				April 19 1995 /2:47 /					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. less	birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	TN	8. BIRTN	IPLACE (State or Foreign		
	048-24-0266	1 🗆 M 2 💢 🗙	62	YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) AUG 24 1					Countr			
	9a. FACILITY NAME (If not institution, give s	street and number)		94	CITY TOWN	OR LOCATION OF DI		932 Connecticut T 9c. COUNTY OF DEATH				
DIRECTOR	Anne Arundel Med				napolis				Arundel			
Ĕ	10e. STATE 10b. COUNT	Y		10c. CITY, T	OWN OR LOCA	TION				10d. INSIDE CITY		
ā	MD Ann	e Arundel			An	napolis				LIMITS?		
	10e. STREET AND NUMBER					. ZIP CODE		10g. CIT	TIZEN OF V	WNAT COUNTRY?		
ER	402 Edgemere Dr	ive				21403		Un	ited	States		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Spec			E — American Indian, k, White, etc.		
	1 Never Married 2 Merried	FORCES? 1 IF YES, GIVE W	YES 2 N	0	II yes, sp	ecify Cuben, Mexice 2 X Specif	m, Puarto Ricen, e	tc.)	Speci			
ВУ	3 Widowed 4 Divorced					- XX	,.		G,Dac.	" White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16e. DE6	CEDENT'S USI	UAL OCCUPATION	ON	16b, KIND (OF BUSINESS/IN	DUSTRY			
Ē	Elementary/Secondary (0-12)	College (1-4 or 5+	life.	Do NOT use re	done during mo Mred.)	st or working				-		
API.	12		l Ho	ousewi	fe			Home		L .		
Ö	17. FATNER'S NAME (First, Middle, Last)					16. MOTNER'S NA	ME (First, Middle, A	Valden Sumame)				
BE C	David Allen					Mai	rion Mur	phy		i		
	19a, INFORMANT'S NAME (Type/Print)		196	. MAILING AD	DRESS (Street a	and Number or Rural			ip Code)			
5	Peter J. Earnest									and 21403		
	20s. METNOD OF DISPOSITION 1 Burlel 2 CyCremetion 3 Rem			ND DATE OF D	ISPOSITION (Na			0c. LOCATION -				
	Donation 5 Other (Specify)	Ioval from State	cemetery, crer	netory or other incoln	Crer	natory 4	1/23/95	Brentw	-boo	Maryland		
	21. SIGNATURE OF FUNERAL SERVICE	CENSE		-11100111	22. NAME A	ND ADDRESS OF FA	CILITY John I	M Tayl	or Fi	uneral Home		
	Htree Dell of	To the			147	Duke of	Gloucest	ter St.	Anna	nolis MD		
	147 Duke of Gloucester St. Annapolis, MD											
	23. PART I. Enter the disasses, or complections that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, enock, or heart failure. Liet only one cause on each line. Approximate interval Between Onest and Death.											
	iMMEDIATE CAUSE (Finel disease or condition	,		401	Tut C	ailuve				Onset and Death		
	resulting in death)	a			VOI T	anove	,		<	SUMONTUS		
		DUE TO	(OR AS A CONSEC	UENCE OF				2000		SMOUTUS		
NO	resulting in death) Sequentielly list conditions,	b	C(DUENCE OF):		avtery		ease	3	s years		
ATION	Sequentielly list conditions, if eny, leading to immediate	b	(OR AS A CONSEC	DUENCE OF):				ease		s years		
FICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	b. DUE TO	(OR AS A CONSEC	DUENCE OF):				Pase	3	s years		
TIFICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING	b. DUE TO	C(DUENCE OF):				Pase		S years		
CERTIFICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente	b. DUE TO	(OR AS A CONSEC	DUENCE OF):				Pase		5 years		
AL CERTIFICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente	b. DUE TO c. DUE TO d	(OR AS A CONSEC	DUENCE OF): DUENCE OF): Deputting in t	avy	avtevy	disc	MS AN AUTOPSY		. WERE AUTOPSY FINDINGS		
ICAL CERTIFICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	b. DUE TO	(OR AS A CONSEC	DUENCE OF): DUENCE OF): DUENCE OF):	avy	avtevy	disc	MS AN AUTOPSY ERFORMED?				
IEDICAL CERTIFICATION	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	b. DUE TO c. DUE TO d	(OR AS A CONSEC	DUENCE OF): DUENCE OF): DUENCE OF):	avy he underlyin	avtevy	disc	MS AN AUTOPSY		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	b. DUE TO c. DUE TO d. DUE TO	(OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF	DUENCE OF):	avy he underlyin	avtevy	Dart I. 24a. W	MS AN AUTOPSY ERFORMED?		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other aignificent condition	b. DUE TO c. DUE TO d. DUE TO	(OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF	DUENCE OF):	avy he underlyin 2005	avtevy g ceuse given in	Part I. 24a. W	MS AN AUTOPSY ERFORMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other algnificent condition DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO C. DUE TO d	(OR AS A CONSECTION OF A CON	DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF):	he underlyin	g ceuse given in ES NO ACE OF DEATN (Ch	Part I. 24a. W PI	MS AN AUTOPSY ERFORMED? YES 2 NO		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other algnificent condition DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	DUE TO C. DUE TO d. THE CONTRIBUTE HOSPITAL: 1 Inpetient 2	(OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF A CONSECTION OF A CONSECTION OF	DOA 4	he underlyin CUVS DEATH Y 26. PI THER: Nursing Nor	g ceuse given in ES NO ACE OF DEATN (Ch	Part I. 24a. W PI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	AS AN AUTOPSY ERFORMED? YES 2 NO	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other algnificent condition DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF TO CAUS ER/Outpetient 3 INJURY ay, Year) F INJURY — At horetc. (Specify) my knowledge, dea	DUENCE OF): DUENC	he underlyin CCUS DEATH Y 26. PI THER: Nursing Norr F 28c. IN. M 1	G Ceuse given in ES NO ACE OF DEATN (Ch 10	Part I. 24a. W PI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	AS AN AUTOPSY ERFORMED? YES 2 NO NO NO Street and Number Street and Number Street and number Street and number street	24b CCURED or or Rural R	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other algnificent condition DID TOBACCO USE (Condition of the condition of the ceuting in deeth) LAST DID TOBACCO USE (Condition of the ceuting in deeth) LAST PART II. Other algnificent condition of the ceuting investigation	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF TO CAUS ER/Outpetient 3 INJURY ay, Year) F INJURY — At horetc. (Specify) my knowledge, dea	DUENCE OF): DUENC	he underlyin CCUS DEATH Y 26. PI THER: Nursing Norr F 28c. IN. M 1	g ceuse given in ES NO ACE OF DEATN (Ch No 5 Residence URY AT RIK? YES 2 NO e and place, end due seath occured at the	Part I. 24a. When the process of the cause(e) art time, date end plant.	AS AN AUTOPSY ERFORMED? VES 2 NO HOW INJURY OC Street and Number State) Ind menner as size Indeed, and due to to	24b CCURED or or Rural F	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,		
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CERTIFICATION

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Pages 1, 2, 3

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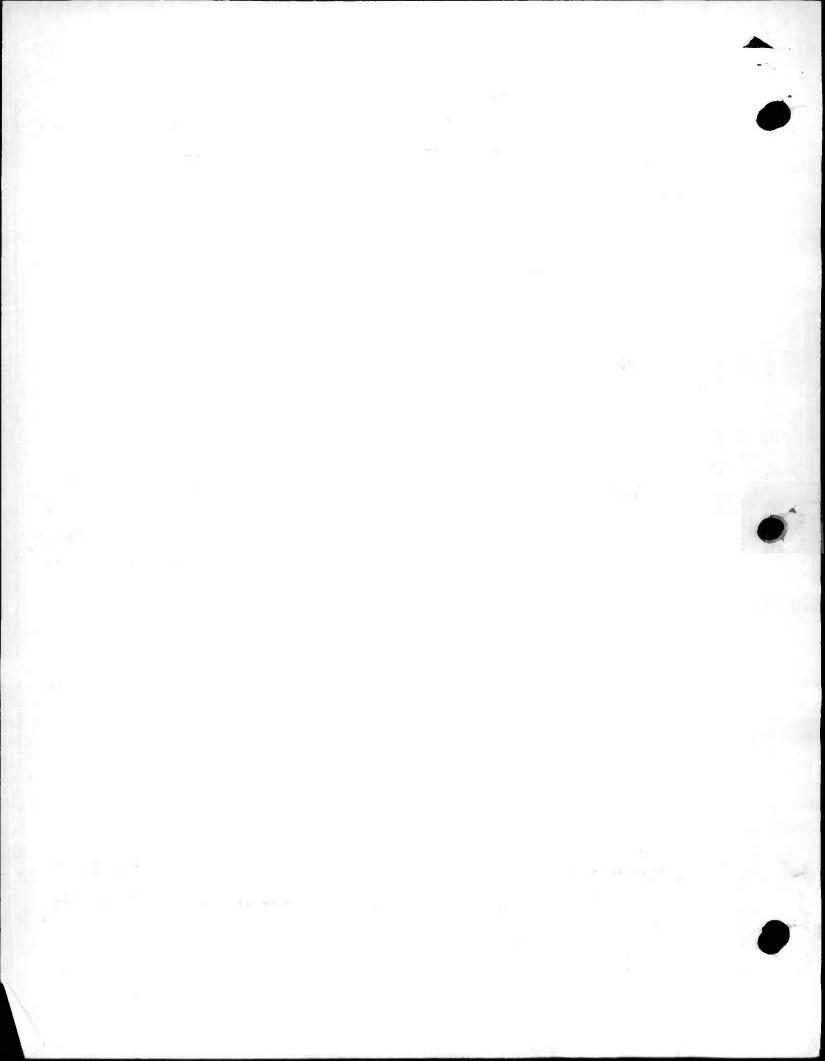
mended item #5 6 and 7	5/1/95 Carroll County P	١. (. (
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JEAN 12.05 PM BONIT EAS 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 213-62-9679 1 - M 2 V F 42 YRS. DAYS HOURS 8/18/52 West Virginia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Carroll County Gn. Hospital Westminster Carroll RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll Westminster 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3523 Ellen Drive 21157 United States 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

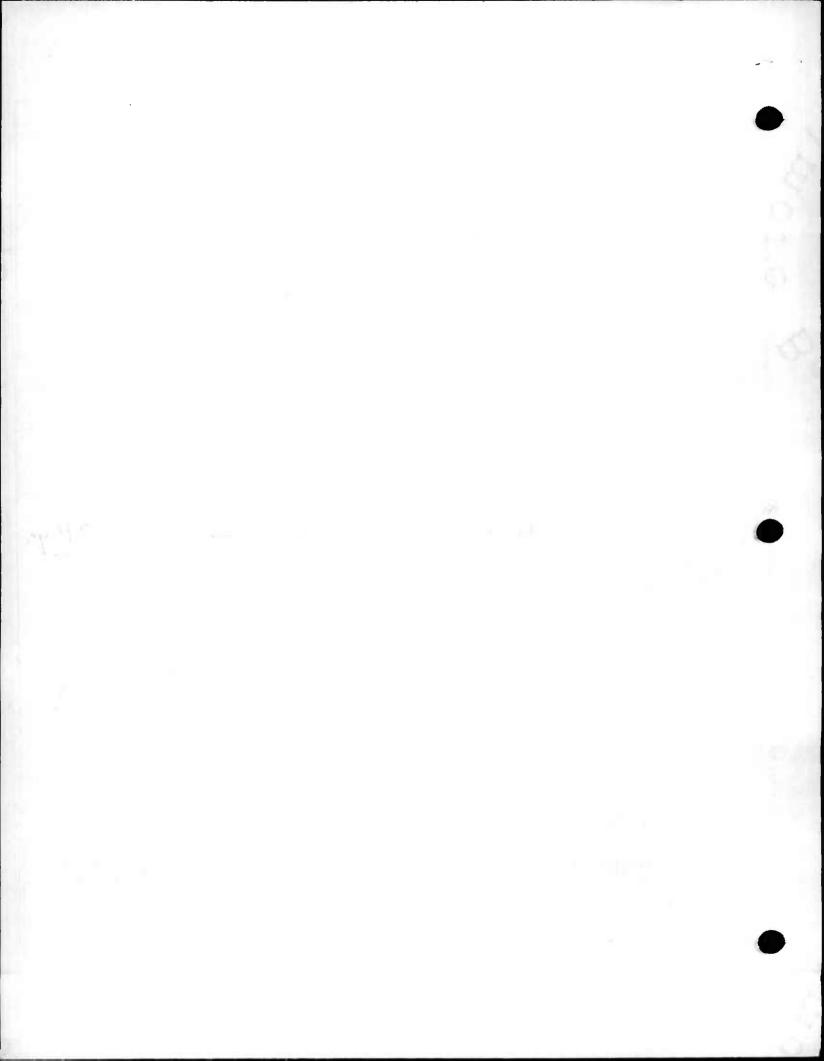
1 YES 2 YOO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2XXMarried 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest live kind of work done

. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Housewife n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Mary Polly Jenkins William Stratton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip 3523 Ellen Drive, Westminster, MD East Jr. 21157 20a. METHOD OF DISPOSITION
XXBurial 2 Cremetion 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 1/28/95 20c. LOCATION - City or Town, Slata 4 Donation 5 Other (Specify). Glen Burnie, MD Glen Haven Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel Katherine 412 Washington Rd., Westminster, MD weither 23. PART I Enter the disease, or complications that caused the disth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition SHOCK SEPTIC Y ardidty resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 48 DISSIMIN ATED INTRU-VASCUL AR CARGULATUR Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate FIBRINO LYSIS ceuse. Enter UNDERLYING WITH CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 Dispettant 2 ER/Outpettent 3 DOA 1 YES 2 NO ng Home 5 - Realdence 6 - Other (Specify) 27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF 1 Natural м 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5 ItOS AT N 132. REGISTRAID SIGNATURE



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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / CE	DEPARTI RTIFIC	MENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH		3. TIME OF DEATH								
		William Granvi	11e Eat	ton				April 24		YEAR			
				E (In yrs. lest	birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1	8. BIRTHPLACE (State or Foreign			
			XM 2 □ F	86	YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6/22/19	08	Country) Maryland			
		9s. FACILITY NAME (If not institution, give street	t and number)		9	b. CITY, TOWN	OR LOCATION OF DE		-	TY OF DEATH			
	O.												
	딦	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
	DIRECTOR	Maryland Carro	011	İ		stmin				10d. INSIDE CITY LIMITS? 14 YES 2 NO			
		10e. STREET AND NUMBER					1. ZIP CODE		to- CITIZ	I-AL YES 2 NO			
	FUNERAL	47 West Green St	treet			"	21157			ed States			
	5	11. MARITAL STATUS 12	. WAS DECEDENT EVER	R IN U.S. ARM	ED	13. WAS DEC		IIC ORIGIN? (Specity Yes		14. RACE — American Indian.			
	BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YE		•	If yes, sp	becity Cubsn, Mexics 3 2 TVNO Specify	n, Pusrto Rican, etc.)		Black, Whits, etc.			
	0 8									Specify: White			
		15. DECEDENT'S EDUCATI (Specify only highest grade con		16a. DECI	EDENT'S US	SUAL OCCUPATION R done during money etired.)	ON ost of working	18b. KIND OF BU	SINESS/INDU	STRY			
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once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Le	ache	T	18 MOTHED'S NA	publi ME (First, Middle, Maiden		10018			
75	В	Richard Bascom	Eaton				Bessi		Weav	70r			
notified	10 B	19s. INFORMANT'S NAME (Type/Print)	20011	19b.	MAILING AL	ODRESS (Street a	4	Route Number, City or Tow					
100	7	Brooks Leahy						, Westmi					
st b		20s. METHOD OF DISPOSITION 1 ☐ Burlel 2 ※ Cremetion 3 ☐ Removal	from State	Ob. PLACE AN	DDATEOF	DISPOSITION (Na	eme of 4/26/	9 5DATE 20c. LO	CATION — CI	ty or Town, Stats			
Ē		4 Donation 5 Other (Specify)		emetery, cremi	etory or other	piace)	tions		amost	ead. MD			
examiner must be		21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE							- 18:01 · 11:00			
		** ** ** ** ** ** ** ** ** ** ** ** **											
other traumatic event, the medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition)											
# ,#		disease or condition resulting in death) e	METASTA	DITA	. {	PROS	TATE	CA		21/41			
ever			DUE TO (OR AS	A CONSEOU	ENCE OF):					12			
natic	NO O	Sequentially list conditions, b	DUE TO (OR AS	A CONSEQUE	FNOT OD								
trau	CATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING											
iệ.	E	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEOU	ENCE OF):								
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shows any injury,	CAL	PART II. Other aignificent conditions co	ontributing to deeth	out not rea	luiting in t	the underlying	g cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
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d, 0	PHY	27. MANNER OF DEATH	28s. DATE OF INJURY	γ	26b. TIME O	F 28c. INJ	URY AT	28d. DESCRIBE HOW II	NJURY OCCU	RED			
marked,	BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	, I	เพากม	Y M 1 □ 1	PRK? YES 2 NO						
.00		3 Suicide 8 Could not be	28s. PLACE OF INJUR building, atc. (Sp	RY — At home	, ferm, stre	et, fectory, office		281. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,			
n 28		4 Homicide determined					i	City of lown, State)					
IMPORTANT: If Item		298. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my kno	wiedgs, deati	occurred a	it the time, dets	and place, and dus	to the cause(s) and man	ner sa stated				
Ë	COMPL	2 MEDICAL EXAMINER: O	n the basis of sxaminat	ion snd/or inv	eatigation, i	n my opinion, d	eath occured at the	time, data and place, an	d dus to the	couse(s) and manner as stated.			
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- 1	10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF D	DEATH (ITEM :	27) (Type, Pri	nt)			- 4	2111			
	- 13	Flavio Kruter	-684A	Poole	et) (Type, Pri	ni) L. We	stmins	ter, Mb 2	1157	22/13			
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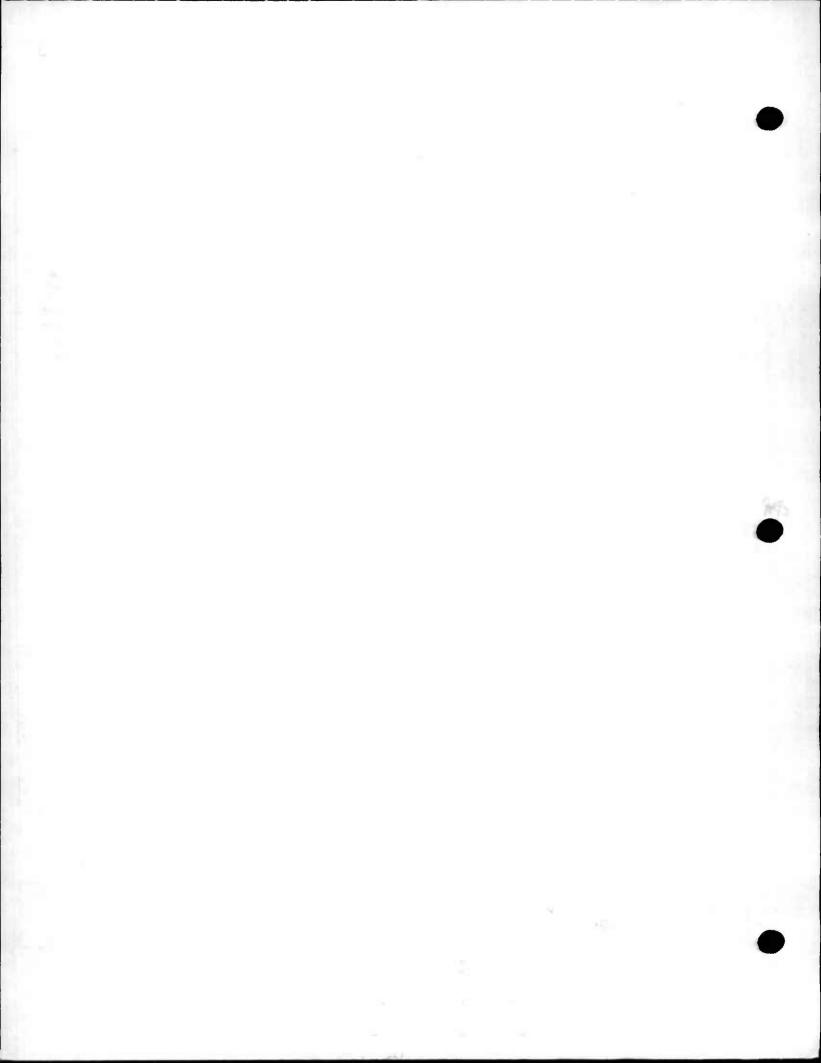
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
ECEDENT'S NAME (First, Middle Lest)		

		1 - STATE REGISTRAR	STATE OF I	WARYLAND C			OF HEAL		MENT	AL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last))				OI DE			E OF DEATH	, <u> </u>		3. TIME OF DEATH
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		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IDER 24 HRS		E OF BIRTH		8. BIRTI	HPLACE (State or Foreign
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		9a. FACILITY NAME (If not institution, give	street end number)			9b. CITY,	TOWN OR LO	ATION OF		• ±//		INTY OF E	
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DIRECTOR		RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT			I son CIT	V TOWAL O	R LOCATION						
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Hed 3		Walter D. Edward 190. INFORMANT'S NAME (Type/Print)	ıs	19	b. MAILING	ADDRESS				dwards mber, City or Tow	orn Chain 70	- Cadal	
를 2		Geraldine H. Edw	Drdc /Wife	16	0315	Balfo	our Dr:	.ve			rii, State, Zij	p (200e)	
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or item 2 YSICIA		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	H (Check o							
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₫ C		27. MANNEB OF DEATH 1 Netural 5 Pending	26e. DATE OF (Month, D		26b. TIM INJ	E OF URY	28c. INJURY A'		26d. DI	EŞCRIBE HOW I	NJURY OC	CURED	
E A	ı	2 Accident Investigation	280 PLACE O	F INJURY — At he	1	M	1 TYES	2 NO					
28 IS TED	1	3 Suicide 8 Could not be 4 Homicide determined	building,	atc. (Specify)	ome, term, a	rreet, racto	гу, опісе			CATION (Street of yor Town, State)	and Number	r or Rural I	Route Number,
Item 2		29e, CERTIFIER											
OMP II			SICIAN: To the best of										
돌		110	4	Automation englor	niveatigatio	n, in my op	inion, death of	cured at t	ne time, de	te and place, en			e) end menner ee stated.
IMPORTANT: If item O BE COMPLE		THE SHONATURE AND XITLE OF CERTIFIE	L				1/2	ICENSE N	16/1/2	4	h /	17	(Month, Day, Year)
≧ ₽		30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CALL	SE OF DEATH #TE	M 27\ /3	Orient)	1	17	90		7	-7	/_>
1		Charles L. Fri	andel for	D I	117.0	WE	12 Hee	unsi	nun	Dun	51.	Q- C	mel regay
1.1	10.		- Whater	RESIDENTE	1100	1-1-1	~ ···	ادرات	ure	LAND	ノル	12)	ring 1
1		31. DATE FILED (Month: 28 year)	ATTENDED TO THE										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Tours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

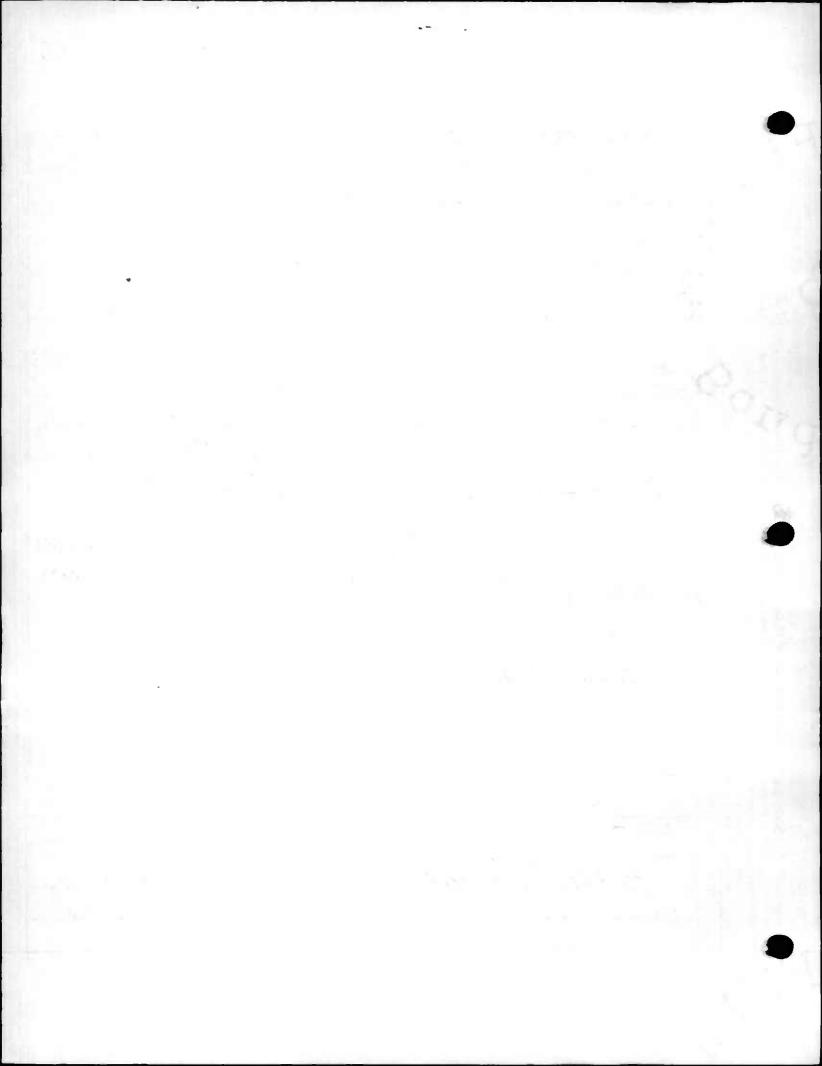
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be nettified at once. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR				CERTIF	ICAL	E OF	DEA	H	RI	EG. NO.				
	1. DECEDENT'S NAME (First, A	Hiddle, Last)								2. DATE OF E	EATH			3. TIME OF DE	ATH
	Mary Ann	Eden	đa						_ 1	April	21		FASY	6:00	2 4
	4. SOCIAL SECURITY NUMBE		5. SEX	A ACE //-					7. DATE OF 8		TEE		IPLACE (State or	a H	
1	4. SOCIAL SECURITY NUMBE	н		e. AGE (In yr		MONTHS	DAYS	HOURS	24 HRS.	(Month, De			Count	ry)	roreign
	247 - 76 - 2	2503	1 🗌 M 2 💢 F	52	YRS.					Apr 30), 19	42	Sout	h Carol	ina
	Sa. FACILITY NAME (If not inst		treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE				NTY OF D		
Œ			7 -			-						_			
2	Manor Care	Nurs1r	ng and Re	ehab.	Center	La	rgo					Pr.	ince	George	
DIRECTOR		10b. COUNTY	1		10c, CI	TY, TOWN	OR LOCA	TION						10d. INSIDE CIT	ry
<u>E</u>														LIMITS?	
	Maryland	Princ	ce George	•	Ne	w Ca								1 [X] YES 2	
4	10e. STREET AND NUMBER						10	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?	
85	5913 85th Pi	lace						20784	4			US	A		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.	S. ARMED	13.	WAS DEC	ENGENT C	F HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RAC	E — American In k, White, atc.	dien.
正	1 Never Married 2 N	larried	FORCES? 1	YES 2	NO		If yes, sp	ecify Cuba	n, Mexica	n, Puerto Rican			Blac	k, White, etc.	
B	3 Widowed 4 Divorc	ed	IF YES, GIVE V	WAR OR DATE:	5		1 NES	2 X NO	Specify	r:			Spec	Black	
	••					- 1								2200.1	
핃	(Specify only	DENT'S EDUC highest grade		18	 a. DECEDENT[*] (Give kind or 	work done	during me		ng	160. KIN	D OF BUS	INESS/IN	OUSTRY		
Щ	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)	life. Do NOT	use retired.)								
9		4	4 Years		Social	Wor	ker			Depa	artme	ent (of S	ocial S	ervic
COMPLETED	17. FATHER'S NAME (First, Mid	idle, Last)						16. MOT	HER'S NA	ME (First, Middle	e, Maiden	Sumame)			
	Rubin Cuffic	^						LO	1100	Ridges	-				
B			· · · · ·		I										
2	19a. INFORMANT'S NAME (Typ	oe/Print)								Route Number, C					
-	Tina R. Mar	tin			1501	Bay	tree	Ter	cace.	, Mitcl	nell	vill	e, M	D 20721	
- 1	20a. METHOD OF DISPOSITIO			20b. Pt	ACE OF OISPI	OSITION (A	lame of ce	metery, cres	netory or		20c. LO	CATION -	- City or Ti	own, State	
	1 Burial 2 Cremetion 4 Donation 5 Other 6		oval from Stata		her place) eenlaw	n Co	moto	2017		4/25	Hard	- evri	116.	8 0	
	21. BIGNATURE DA FUNERAL	77	CENTRE -	- GL	eentaw			ND ADDRE			nar	LSVI	TTE	D.C.	
	. 6111	111		11							Home	, P.	Α.		
	P(////2	4 /	X		Donaldson Funeral Home 313 Talbott Ave. Laure									and 207	07
-	23. PART I. Enter the off	11	ammiliant and the		a death De										
	ahock, or he	art fallure.	List only one cer	use on aach	ia geaul. Do	not ante	er tine me	ode of dy	ing, suc	n aa cardiec	or reapi	ratory a	rreat,		Between
	IMMEDIATE CAUSE (Fine				1)	_						Onset a	nd Death
	disease or condition	4	1	9701	101		din	10	1					14-5	400/1
	resulting in death)		a. DUE TO	OR AS A CO	ONSEQUENCE	OFI:	~							7-	5
_			M	1 10	I to			(~1						7140	80
CERTIFICATION	Sequentielly list condition	ons.	b. ///	1as	IGNIC		w	(2)	•					20%	01)
Ĕ	if any, leading to immed	late	DOE TO	(OR AS A CC	MSECUENCE	OF):								i	
3	cause. Enter UNDERLYIN CAUSE (Disease or injur		с												
E	that initiated events		DUE TO	(OR AS A CO	ONSEQUENCE	OF):									
E	resulting in death) LAST		4												
핑			4.												
	PART II. Other aignificar	nt condition	na contributing to	death but	not resulting	in the u	inderlylr	g cause	given in	Part I. 24	. WAS AN		24	b. WERE AUTOPSY	
EDICAL	Deh	10/2	allon								PERFOR			COMPLETION O	
	2017	7-1	N. D. L. V.							''	YES 2	KNO	- 1	OF DEATH?	
Σ	- 0	8								_				1 YES 2	NO
										_					
PHYSICIAN:	25. WAS CASE REFERRED TO	MEOICAL					26. F	LACE OF	DEATH (Ch	eck only one)					
2	EXAMINER?		HOSPITAL:	E9/Cutacit	nd 3 🗆 nos	ОТН			anddo	4 [] Other 10	necita's				
Ϋ́	27. MANNER OF DEATH		28a. DATE O		_	ME OF		JURY AT	warderice	6 Other (S)		M HINN A	COMME		
급		Pending		Day, Year)	200.	NJURY	W	ORK?		28d. UEŞCHI	BE NOW I	NJUNT O	CCOMED		- 1
В		nvestigation				M	1 🗆	YES 2	NO						
	a C autota	Could not be			At home, farm	, atroot, fo	ctory, offi	ce					er or Rural	Route Number,	
Ш		letermined	Duncting	, etc. (Specify)						City of R	own, State)				
COMPLETED	no centrer										-				_
4	(Orietta trilly	FYING PHYS	ICIAN: To the best of	f my knowled	ge, death occu	rred at the	time, del	a and plac	e, and due	to the cause(e) and ma	nner as s	tated.		
2	one) 2 MEOR	CAL EXAMINE	ER: On the basis of	examination a	nd/or investiga	tion, In my	opinion,	death occi	ared at the	time, date and	d place, ar	nd dua to	the cause	(a) and manner a	s stated.
	296. SIGNATURE AND TITLE	OF CERTIFIE		7		-		I 200 1 1/	SENIOE AND	MOCO		T 204 D4	TE CIONE	D (Manth Day W	eal
BE	AND THE	20	1	1/10	1///	1)		29C. LK	2/1	7/1		290. 00	I /	D (Month, Day, Ye.	· ·
	700	///	1 6	1191	11/			V	24.	-17			4-1	41-5) .
2	30. NAME AND ADDRESS OF	PERSON WI	HO COMPLETED CAL	JSE OF DEATH	H (ITEM 27) (Ty	pe, Print)				1			*		
	Sam Tellawi	. м т	4000	Mital	halleri	ו בוו	Seo 2	Sinia	רת ם-	112 P	N.71 ^	Mas	ربرا مــ	nd 2071	, I
- 2	31. DATE FILED (Month, Day,			AR'S SIGNATI		TTC	wad	DUL	E AJ	LICI DO	wie	LIG.	ГАТО	14 20/16	
		1005	11116	4	0 .										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flowrs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERI	LIFICA	TE OF	DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) Ada			า	April 18°	2. DATE OF DEATH 3. TIME OF DEATH 2030						
	4. SOCIAL SECURITY NUMBER 213-34-5240	5. SEX 1 M 2 X F	78 YF	RS. MONT	NDER 1 YEAR THE DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 14,19	916	Country)	LACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give st	reet end number)		9b.	CITY, TOWN	OR LOCATION OF DE		v	INTY OF DE			
DIRECTOR	Calvert Memorial			Prince	e Frederi	ck	Ca	1vert				
RE	10a. STATE 10b. COUNTY		10c	C. CITY, TOV	WN OR LOCA	TION				10d. INSIDE CITY LIMITS?		
		vert		Dun	kirk				- 1	1 - YES 2 X NO		
₹	10e. STREET AND NUMBER				10	. ZIP CODE		10g. CIT	IZEN OF WI	AT COUNTRY?		
剪	9798 Howes Road					20754		U	ISA			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEOENT I FORCES? 1 [IF YES, GIVE WAS	YES 2 X NO		If yes, sp	ENDENT OF HISPAN ecify Cuban, Mexical 2 NO Specify	IC ORIGIN? (Specify Yer n, Puerto Rican, etc.)	or No—		- American Indian, White, etc. Black		
		T							<u> </u>			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16e. DECEDE	nd of work di	one during mo	ON ost of working	16b. KIND OF BU	SINESS/INI	DUSTRY			
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	2000	IOT use retin	,			1.				
ž l	17. FATHER'S NAME (First, Middle, Last)		ро	mest	LC		Someone		e's h	ome		
	George	Evans				I .	ME (First, Middle, Melden	-				
BE	19a. INFORMANT'S NAME (Type/Print)	Evalis	-			Annie			itche	11		
6	Annie Rawlings						loute Number, City or Tow		p Code)	*		
							rk, MD 207					
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 6 Other (Specify)	oval from State	20b. PLACE AND D. cemetery, cremetory MOSES	ATE OF DIS	POSITION (NE BCB) Cery	4/24 4	OATE 20c. LO	cation —	n. MD	n, State		
	21. SIGNATURE OF FUNERAL SERVICE LIC	-				ND ADDRESS OF FAC	UI Laure Control					
	* Spencer			Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD deeth. Do not enter the mode of dying, such as cardiec or reepiretory streat, Approximate								
	iMMEDIATE CAUSE (Finel	DUE TO (O	on each line.					retory sn	reat,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
		-										
EDICAL	PART II. Other significant conditions	4.5	Α		Underlying	g cause given in i	Part I. 24a. WAS AN			VERE AUTOPSY FINDINGS		
움Ⅱ	(crbs)	45(4)(Hend	ut			1 YES 2			COMPLETION OF CAUSE OF DEATH?		
E I										YES 2 NO		
	DID TOBACCO USE CONTR	RIBUTE TO CAU	SE OF DEATH	YES [] NO ₹	UNCERTAIN						
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	-								
Š	1 TES 2 NO	1 Inputient 2 E	R/Outpatient 3 🗆 DC	OA 4 □	HER: Nursing Hom	e 5 Residence	B ☐ Other (Specify)					
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF IN. (Month, Day,		TIME OF INJURY	28c. INJ WO 1 1 1	RK?	26d. DESCRIBE HOW I	NJURY OC	CUREO			
	3 Suicide 6 Could not be determined	28e. PLACE OF II building, etc	NJURY — At home, ta :. (Specify)	erm, street,	tectory, office		261. LOCATION (Street e City or Town, State)	and Number	or Rural Roo	ite Number,		
COMPLETED							to the ceuse(e) end mer					
S I	one) 2 MEDICAL EXAMINER	: On the beels of exen	nination end/or investi-	igation, in r	my opinion, d	eath occured at the t	ime, date end place, en	d due to th	ne ceuse(s) (and menner se stated.		
8	290. SIGNATURE AND TITLE OF CENTIFIES	1)				29c. LICENSE NUM	BER 7	29d. DAT	E SIGNED (A	Aonth, Day, Year)		
요 🖁	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF OFATH ATEN OF	/Ema (1-1		U 531	15		1-10	-75		
				(rype, Print)	D×	ince Pro	derick, MD	20	678			
	Dr. Jonatho			4	FL	THE LFG	GETCK LIF	20	0,0			
	31. DATE FILED (Month, Day, 1804) 32. REGISTRAR'S SIGNATURE APR 21 1995 Julia Stavillar Randall											
		-										

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	I from 28 is marked or item 23 shows any intervent and intervent or other trainfile event the medical assummer he medical assumed he notified at some
rSICIAN: The law requires that th	certificate has been signed by the	th the State Dept. of Health and	d or item 23 shows any in
HE HOSPITAL OR ATTENDING PHY	FUNERAL DIRECTOR: After this	filed within 72 hours after death with	TANT: If item 28 is market
黑	开	filed	IPOS

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A32. RÉGISTRANT SIGNATURE

FARZAD

APR 25 1995

ASSAR, M.D.

=

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

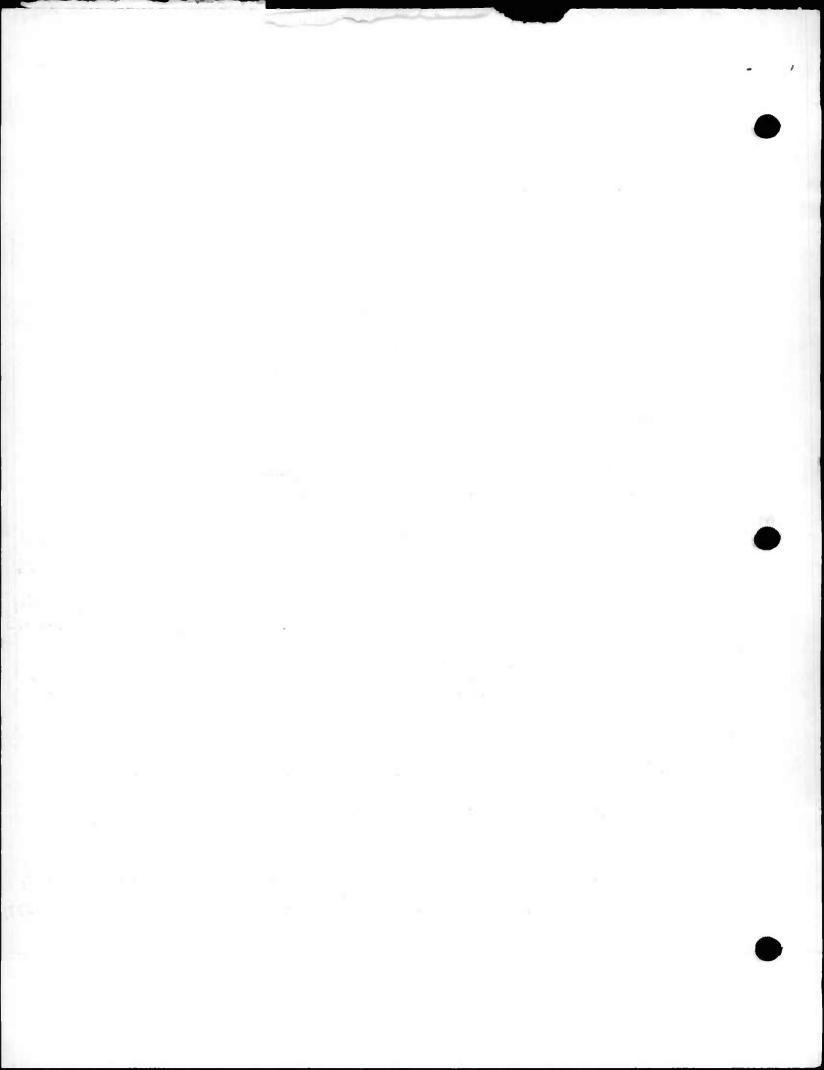
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (FIRST. MERIODES)] ine EVA FLICKINGER 2. DATE OF DEATH 3. TIME OF DEATH 04 2:25 am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH 8. BIRTHPLACE (State or Foreign Sept. 28,1910 213-16-9296 84 YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Westminster Nursing & Conval.Ctr. Westminster Carroll RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Carroll Westminster 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21157 U.S.A. 73 Pennsylvania Ave 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No- RACE — American Indian, Black, White, atc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntery/Secondary (0-12) College (1-4 or 5+) Assembley Manufactory 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Dull Emma Grace Gamber 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 1081, Bethany, June A. Borchers Okla. 73008 20a. METHOD OF DISPOSITION
1 St Burlel 2 Cremetton 3 Removal from State
4 Donatton 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Cemetery Westminster, Md. Johnis 21. SIGNATURE OF PUMERAL SERVICE LIÇENSEL 22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home divy 254 E. Main St. Westminster, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death failure -> Cessation of disease or condition respiratory started resulting in death) 2:00 AM Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediata Hepatie cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events including CHF. ou 4-25-95 reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO interstitia Loug COMPLETION OF CAUS Heart disease, Advanced 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
4 M Nursing Homa 5 Residence 8 Other (Specify) 1 YES 2 NO 1 | Inpelient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 26b. TIME OF INJURY 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be deferminad 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. S MEDICAL EXAMINER emination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and menner ea stated. 296 AND TITLE OF 29c. LICENSE NUMBER
D-40201 29d. DATE SIGNED (Month, Day, Year)

4 - 25-95 9 Jarsen (M.D.

MT AIRY 21771

1502 S. MAIN ST.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 4-22-95 11:25AM REG. NO 1. OECEDENT'S NAME (First, Middle, Last) Lawnence Vernon Freeman EEMAL 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1125 AM 22 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 - F YRS. 218-12-9687 70 June 29 1924 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10b. COUNT 19c. CITY TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7 Spruce Lane page 5 should be detached for use as the burial-transit 21401 United States retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 10 TES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puarto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Narried BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 186. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Stockman US Naval Academy 17. FATHER'S NAME (First Middle Leet) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 듆 Lawrence V. Freeman Mary Agnes Trott BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Millie Ann Freeman 7 Spruce Lane Annapolis, Maryland 21401 hours after death. Page 6 may be ě 20a. METHOD OF DISPOSITION

1 X Murial 2 Cremation 3 Real A Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must funeral director, Maryland Veterans Cemetery 4/25/95 Crownsville, MD examiner NATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD n by the freenoval. M medical 21. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, n and completely filled in by to burial, cremation, or remo Approximate shock, or heart fallure. List only Interval Bety IMMEDIATE CAUSE (Final Onset and Death the diseese or condition reaulting in death) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions, if sny, leading to immediate failure uires that the death certificate be a signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other 1 that initiated events (OR AS A CONSEQUENCE OF) resulting in death) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? requires that any 1 TYES 2 TLNO OF DEATHS shows a 1 TYES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: . OR ATTENDING PHYSICIAN: The law in DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 ETED 8 Could not be 58 4 Homicide determined item COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

David S. McHold, M.D. 116 Defense Hwy. #200 Annapolis, MD 21401 (410-224-2414)

29c. LICENSE NUMBER

D07327

TO THE HOSPITAL TO THE FUNERAL OF the filed within 72 h HOSPITAL

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIER

25 1995

31. DATE FILED (Month, Day, Year)

meHold

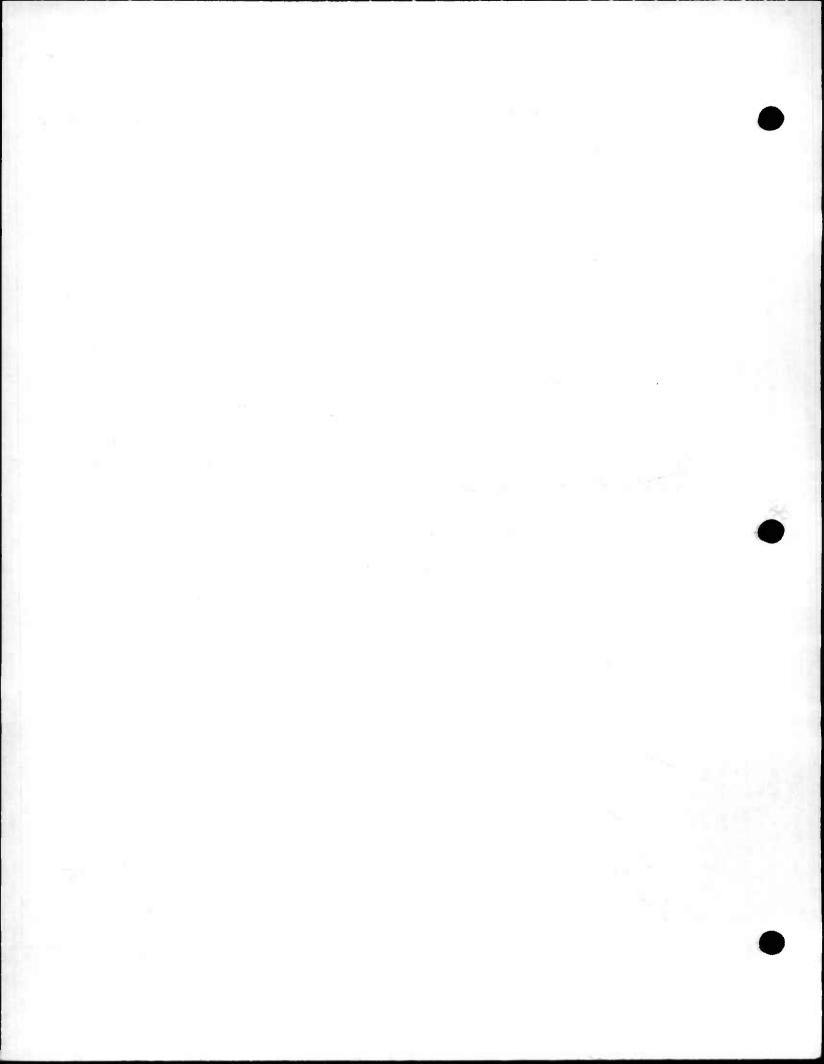
32. REGISTRAR'S SIGNATURE Jalia Davidson Revolate

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29d. DATE SIGNED (Month, Day, Year)

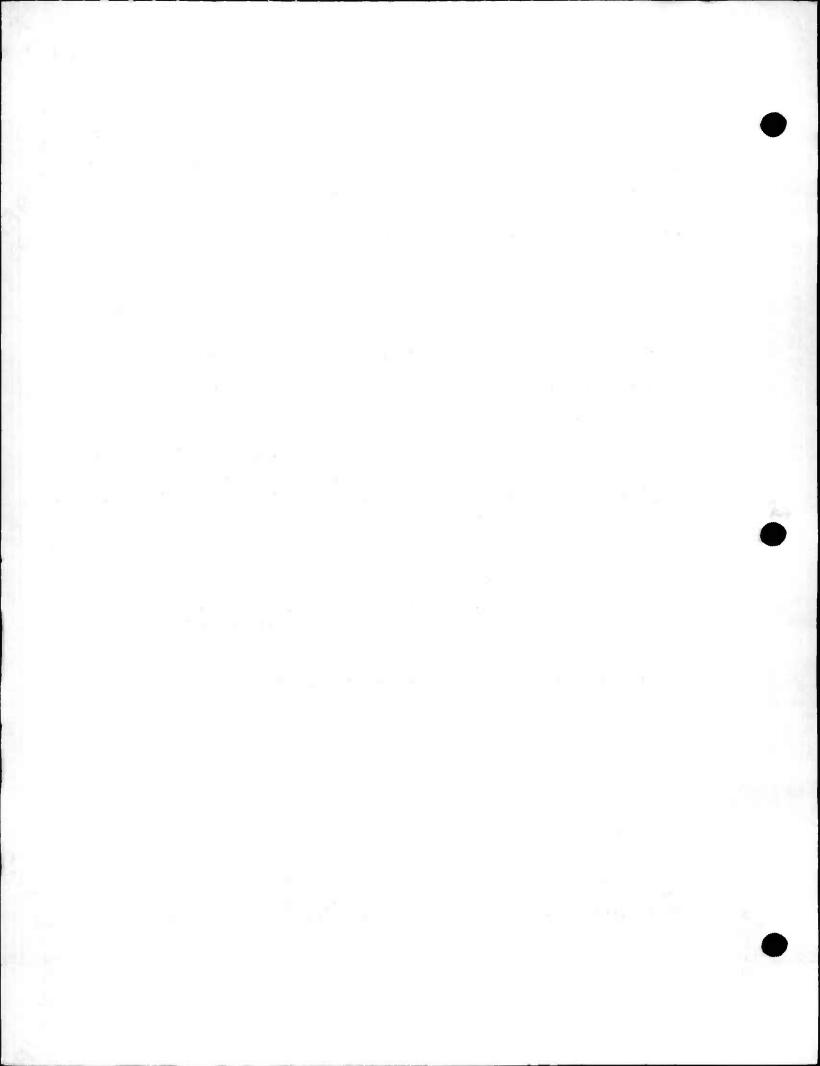
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	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dire-
3	after (by the
	hours	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
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	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH	DAY	YEAR 3. TI	ME OF OEATH	-
- 8	Everett	R.	Ford			April	11, 1	995 12		M
	4. SOCIAL SECURITY NUMBER 578-10-4603	1√XM 2 □ F 79	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTTH (Month, Day, Year) 10/9/15		Virgin:	E (State or Foreign 1a	
DIRECTOR	98. FACILITY NAME (If not institution, give a Western Maryland RESIDENCE OF DECEDENT			Hagers	OR LOCATION OF D	EATH		ington		
EC	10e. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCA	TION			10d.	INSIDE CITY	_
	Maryland Washi	ngton	Boor	nsboro					LIMITS? YES 2 \(\) NO	
FUNERAL	100. STREET AND NUMBER 213 South Gate Di	r.		-	1. ZIP COOE 21713		USA	EN OF WHAT	COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Divorced	12. WAS DECEOENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DEC	CENCENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Ricen, etc.)	ea or No-	14. RACE — Ar Black, Whit Specify: White	merican Indian, ia, atc.	
E	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US	rk done during mo	ON ost of working	16b. KIND OF B				-
PLET	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Delivery	retired.)	•	Milk				
COMPL	17. FATHER'S NAME (First, Middle, Last)	-	Delivery	indii	18. MOTHER'S NA	AME (First, Middle, Maide	n Surname)			_
ш	Everett P. Ford	1			Hazel		,			
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To	wn, State, Zip (Code)		_
	Thelma E. Ford	1 200		as item						_
	1 N Buriel 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval trom State	b. PLACE AND DATE OF metery, crematory or other ASDINGTON	Nation	al Cem.	OATE 200. L 4/14/95 St	iitlan	ity or Town, St	ate	
	21. SIGNATURE OF TUNERAL SERVICE LIC	CENSEE		22. NAME AI	ND ACCRESS OF FA	CILITY				-
	"Thomas P.	Kales . h.	,			as Füneral 1 Rd. Oxor		Md '	20745	
	23. PART I. Enter the diseases, or shock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Sepsis	ach lina. A CONSEQUENCE OF):	centar tha mo	da or dying, suc	th as cardiac or rea	piratory arre		Approximate interval Batweer Onset and Desti	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): End—stage renal disease on continuous ambulatory OUE TO (OR AS A CONSEQUENCE OF): peritoneal dialysis d.									
MEDICAL	PART II. Other significant condition Congestive hear	e contributing to death b	out not resulting in	the underlying	g cause given in disease	Part i. 24s. WAS A PERFO	RMED?	AVAIL/ COMP OF DE	AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE EATH? YES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF OEATH (Ch	eck only one)				-
ı ∠	1 TES 2 X NO 27. MANNER OF DEATH	1 X Inpetient 2 - ER/Outp	patient 3 DOA 4			6 Other (Specify)				
ВУ РНУ	1 X Natural 5 Pending 2 Accident Investigation	26e. PLACE OF INJURY 26e. PLACE OF INJURY	26b. TIME (M 1 1	RK? YES 2 NO	28d. OEŞCRIBE HOW	INJURY OCCU	PRED		
ETED	3 Suicide 6 Could not be determined	•	261. LOCATION (Street City or Town, State		Rural Route N	umber,	Des			
COMPLE		CIAN: To the best of my know R: On the basis of examination							nenner se stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1 . 1			29c. LICENSE NUI	MBER	100	SIGNED (Month		-
2	30. NAME AND ADDRESS OF PERSON WHO	NCULO	ATH (ITEM AT)		D12642			ril 11	1, 1995	
	Fe U. Porciuncula	. M.D. 150	0 Pennsyl	weste	ern Maryl Ave., Hag	land Cente gerstown,	r MD 21	742		
	31. DATE FILEO MACHE DOY, YOUT 1995	32. MEGISTRAR'S SIGN	on Randall							



ND	G PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Dane 6 may be retained by the hourstall
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BALTIMORE, MARYLAND	Paring P
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N OF VITAL RECORDS, P.O. BOX 68760	HYSICL
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY FLOOK 21, 1995 0340 April Alice. Marie 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 F 220-18-0242 Virginia Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Frederick Frederick 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1X YES 2 NO Maryland Frederick Frederick permit. FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10.8 Frederick Avenue

11. MARITAL STATUS

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES use as the burial-transit 21.701

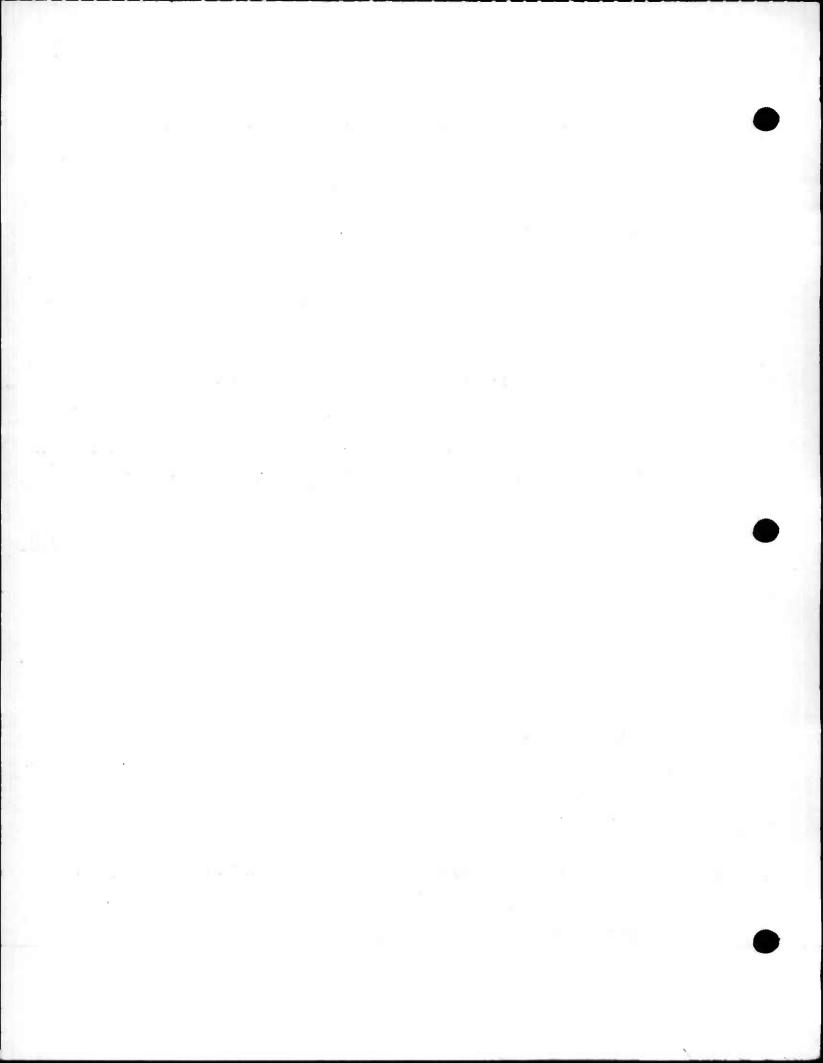
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: U.S.A. attending physician. 14. RACE — American Indian, Black, White, etc. 3 Widowed 4 Divorced Specify: White B√ ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondery (0-12) ò College (1-4 or 5+) COMPL 8 Assembly lineperson Optical company 5 should be detached notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Lewellyn L. Whittington Nettie Elizabeth Burke BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9 108 Frederick Ave., Frederick, Maryland 21701 Carol E. Whittington page pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State examiner must director, 1 Buriel 2 Cremellon 3 Re 4 Donation 5 Other (Specify) rial Gardens Apr 22. NAME AND ADDRESS OF FACILITY 1995 Frederick, Md. sthaven Memorial 21. SIGNATURE OF PUNERAL SERVICE LICENSEE the funeral Keeney and Basford Funeral Home Where M00021 106 East Church Street, Frederick, filled in by the Item 23 shows any injury, or other traumatic event, the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate shock, or heart failurs. List only one cause on each line Interval Batwean cremation, or IMMEDIATE CAUSE (Finel Onset and Death ASCUD disease Dr condition the attending physician and completely formation in Mental Hygiene prior to burial, cremation DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO JOR AS A CONSEQUENCE OF If any, leading to immediats cause. Enter UNDERLYING CAUSE (Diseass or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in dasth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS been signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate f OSPITAL: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 -4 Nursing Home 5 Residence 8 Other (Specify) marked, or TO THE HOSPITAL DR ATTENDING PHYSICIS TO THE FUNERAL DIRECTOR: After this cert be filed within 72 hours after death with the IMPORTANT: If Item 28 is marked, o 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER HYSICIAN: to the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner ee stated. (Check only one) 2 MEDICAL EX stion end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner ee stated. MINER: O 29b. SIGNATURE AND TITUE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

4/24/91 BE 912 meloca 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D., Parkview Medical Center, Frederick, Maryland 21701 Julio Menocal,

32. RECISTRAR'S SIGNATURE

Julia Davolson Rantall



DIVISION OF VITAL RECORDS, P.O. BOX 68760

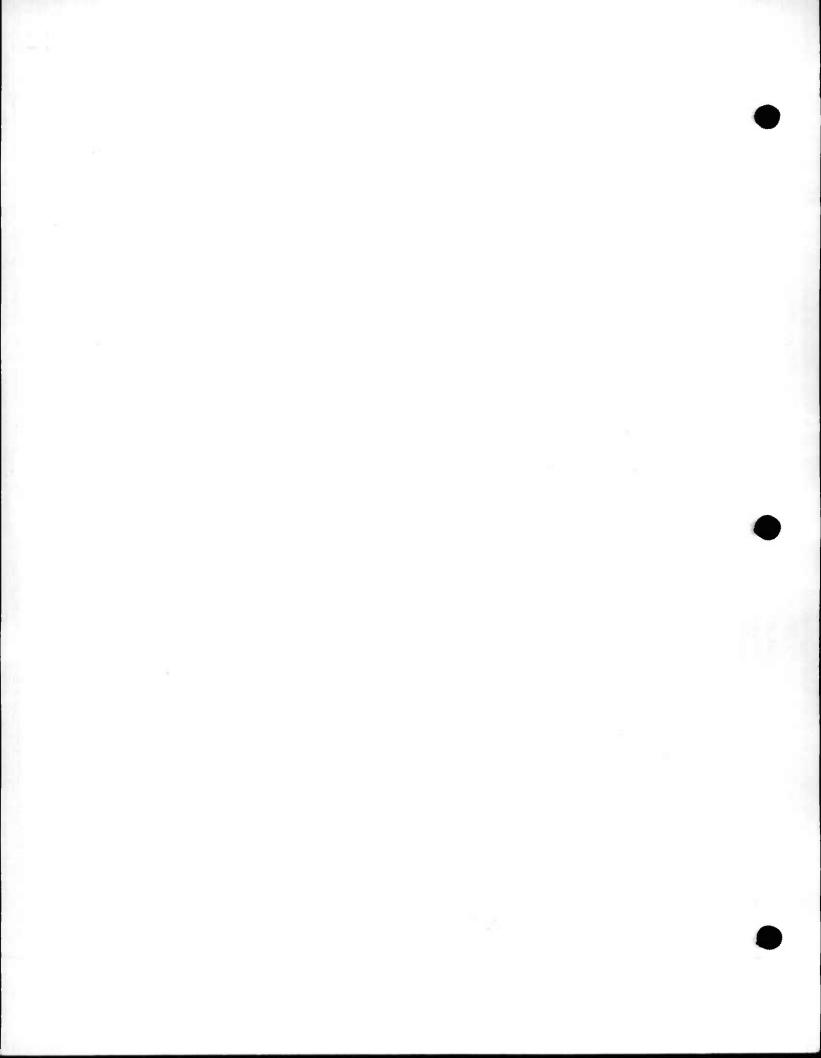
31. DATE FILED (Month, Day, Year)
APR 17 1995

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC	MENT OF HEALTH	AND MENTAL HYGIE		
	16	1. DECEDENT'S NAME (First, Middle, Lest) GEORGE	KIM		FRICK	2. DATE OF DEATH MONTH April 15,	DAY Y	3. TIME OF DEATN
	١.	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	F UNDER 1 YEAR IF UNDER	24 HRS. 7. DATE OF BIRTH		02:50 A BIRTNPLACE (State or Foreign
PS		173-12-5505 9a. FACILITY NAME (If not institution, give stri	1 X M2□F 78	YRB.	ONTHE DAYS HOURS	MIN. APRIL 28		BIRTNPLACE (State or Foreign Country) PA.
2, 3 should	D.	Memorial Hospital			Cumberland	ON OF DEATN	Alleg	
- Sec 1	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY
mit. Pa	100	MARYLAND ALLE	GANY	LA	VALE			1 TYES 2 NO
DAVSICIAN. Durial-transit permit. Pages 1,	FUNERAL	607 NORTH FIRST S	TREET		21502		U.S.	A .
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	13. WAS DECENDENT O	F NISPANIC ORIGIN? (Specify n, Mexican, Puarto Rican, etc.) Specify:	Yea or No— 14	. RACE — American Indian, Black, Whita, etc. Specify: WHITE
or attending or use as the	COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade o	ompleted)	16a. DECEDENT'S US (Give kind of wor	BUAL OCCUPATION is done during most of working etired.)	16b. KIND OF E	BUSINESS/INDUS	TRY
S S S	MPLE	Elementary/Secondary (0-12) 12+ 4	College (1-4 or 5 +)	CHIEF CHE	-	1	PRINGFI	ELD TIRE CO.
t de de	11	17. FATNER'S NAME (First, Middle, Last) GEORGE D. FRICK			100000000000000000000000000000000000000	NER'S NAME (First, Middle, Maid HERINE KIM	en Surname)	
retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A		or Rural Route Number, City or 1	own, State, Zip Co	ode)
De 5		WILMA FRICK		607 NOR	TH FIRST ST	REET LAVALE,	MARYLA	ND 21502
6 may ector, pa		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove 4 Donation 6 Other (Specify)	ral from State 20b	PLACE AND DATE OF		DRTI 16 1995	CUMBER	y or Town, Stata LAND MARYLAND
Pag di di		21. SIGNATURE OF FUNERAL SERVICE LICE	MEE , III	IIDERERIO	22. NAME AND ADDRES			DAND HARTBAND
er death. the funer val.		Dale Z. 11	eruts		404 DECATU	R STREET CUM	BERLAND	
filled in by the on, or removal.		23. PART i. Enter the diseases, or co shock, or heart fallure. Li	mplications that caused at only one cause on a	the deeth. Do not sch lina.	enter the mode of dyl	ng, such as cardiac or res	piratory arrest	Approximate Interval Between
		IMMEDIATE CAUSE (Final disease or condition	Toolin	1010	M. J.	la a a t	17	Onset and Deat
completely ial, cremati		resulting in death)	DUE TO JOR AS A	CONSEQUENCE OF:	Jaga	andons	X	de Lans.
and o burn	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO JOH AS A	CONSEQUENCE OF	eso	00	+	78 years
ficate be physician ne prior t	RTIFICATION	ceuse. Enter UNDERLYING CAUSE (Disease or injury					V	
. 유명숙 등	1 20 1	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				i
the death the atte		PART II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause o	river in Part I Tata was	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
# 55	S				and another young success		ORMEDS	AVAILABLE PRIOR TO COMPLETION OF CAUSE
w requires the been signed pt. of Health and Schools a	MEDI	DID TOD 4 550 1155 501 1151				- 7		1 YES 2 NO
2 8 8 6	NA I	DID TOBACCO USE CONTRI 25. WAS CASE REFERSED TO MEDICAL	and the second s	F DEATH YES 26. PLACE OF DEATH	Application of the Company of the Co	ERTAIN		
SICIAN: The lar certificate has the State Dep		1 YES NO	HOSPITAL: Inpatient 2 - ER/Dutp		THER:	sidence 8 🗆 Other (Specify)		
NG PHYSIC fler this cer eath with th		27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Dep. West)	25b. TIME C	Y WORK?	28d. DESCRIBE HOV	MJURY OCCUR	ED
NDING R: After or death		Accident Investigation Suicide S Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	At home, ferm, stre	M 1 YES 2 NO m, street, factory, office 281. LOCATION (Street and City or Rown, State)			Purel Route Number,
HO DIR	LET		AN: To the heat of our beaut					
TO THE HOSPITAL TO THE FUNERAL (be filed within 72 h	COMPL					and due to the cause(s) and med at the time, date and place,		sube(s) and manner as stated.
HE HO HE FUI led with	BE C	396. SIGNATURE AND TITLE OF CERTIFIER		· 1		NSE NUMBER	29d. DATE SI	
5 5 3 M	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAURE OF DE	ATN (ITEM 97) (See	(nt)	12119	In	TIO (2)0
12		Dr. W. Guy Fiscus				., 500Memoria	1 Ave	Cumberland

32. REGISTRAR'S BIGNATURE

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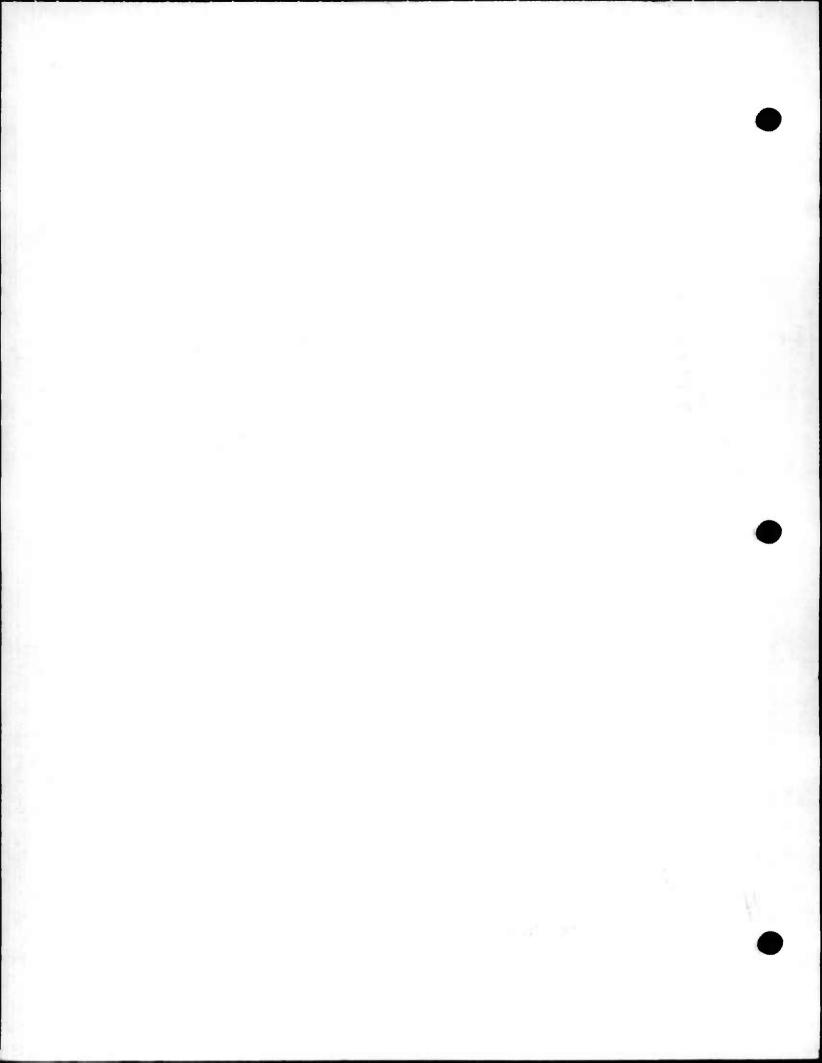
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BALTIMORE, MARYLAND 21215-0020

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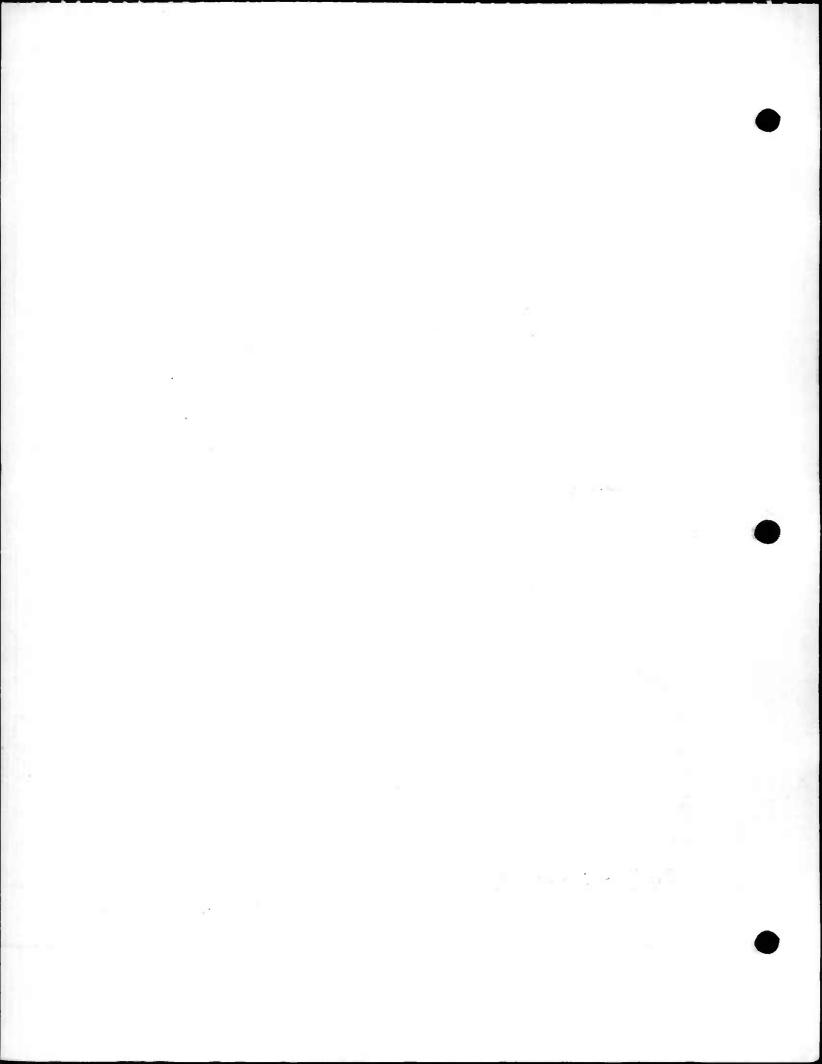
		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF	HEALTH AND		YGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) Madeline	C.	Fletcher			2. DATE OF MONTH April	DEATH	1995	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 220-10-7546	5. SEX 6. AG	GE (In yrs. last birthday) 7 3 YRS.	IF UNDER 1 YEAR		7. DATE OF I	BIRTH ex. Year)	6. Bil	RTHPLACE (State or Foreign untry)
	~	9a. FACILITY NAME (If not institution, give str	reet and number)	/3		/N OR LOCATION OF D		7,1921	COUNTY OF	RYLAND
	DIRECTOR	WESTERN MARYLAN				ERSTOWN		h	ASHI	NGTON
	DIRE	MARYLAND ALLE	EGANY		Y, TOWH OR LO					10d, INSIDE CITY LIMITS? 1 X YES 2 NO
	RAL	100. STREET AND NUMBER 1000 HAROLD DRI	r v E			101. ZIP CODE		10g		F WHAT COUNTRY?
	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARMED	13. WAS I	21502 DECENDENT OF HISPA appecify Cuban, Maxico	NIC ORIGIN? (S	specify Yes or No	U.S.	ACE — American Indian, lack, White, etc.
	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			res 2 X NO Specia		n, atc.)		pecify: WHITE
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of tilfe. Do NOT us	USUAL OCCUP work done during se retired.)	ATION most of working	16b. KIN	D OF BUSINES	S/INDUSTRY	Y
Ce.	MPL	17. FATHER'S NAME (First, Middle, Last)	2	REGIST	ERED 1			JRSING		
d at once.	BE CC	DEWEY SHEPHERD				MARGA		HANHOL		
notified	10	190. INFORMANT'S NAME (Type/Print) PAUL FLETCHER				AVEBL				21523
u. examiner must be		20a. METHOD OF DISPOSITION 1	rval from State	COMBERLA	OF DISPOSITION	(Name of	4/1/95	20c. LOCATIO	N — City or	
miner		21. SIGNATURE OF FUNERAL BERVICE LICE	INSEE	ZUMBERLA	22. NAME	AND ADDRESS OF FA	IRCH F	FUNERA	L HO	ME, P.A.
medical exa	Ī	23. PART I. Enter the diseases, proceedings of the control of the	mplications that cause	sed the deeth. Do r	[202	GREENE :	STCl	JMBERL	AND.	MD 21502
		IMMEDIATE CAUSE (Final	lat only ona cause on	each ling.	or antar tre	moda bi dying, suc	III SS Cardiac	or respirator	y srrest,	Approximate interval Between Onest and Death
vent, ti		disesse or condition reaulting in death)	Pneumonia	S A CONSEQUENCE OF	F):					4/5/95
or other traumatic event, the	NO	Sequentially list conditions,	End-stage	COPD -	Vent:	ilator D	epend	ent		6 years
er trau	ICAT	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury								
y, or oth	CERTIFICATION	that initiated events reaulting in death) LAST		S A CONSEQUENCE OF	=): 					
inur	CAL C	PART II. Other significant conditions	contributing to death	but not resulting	n tha underly	ring cause given in	Part I. 24s	. WAS AN AUTO		4b. WERE AUTOPSY FINDINGS
ws any	MEDIC	Cerebrovascular Disease, Osteop		, Seizu	re, Pa	agets	10	YES 2 XN		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
23 shows		DID TOBACCO USE CONTR					N 🖾			1 YES 2 NO
Item	SICIAN		HOSPITAL: 1 tV Inpetient 2 ☐ ER/O	26. PLACE OF DEAT	OTHER:	ome 5 - Residence	B C Other (So	anc#h/l		
marked, or	УНЧ /	27. MANNER OF DEATH 1 X Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year		E OF 28c.	INJURY AT WORK?		BE HOW INJURY	OCCURED	
28 is ma	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJUI building, atc. (Sp	RY — Al home, farm, a			26f. LOCATIO City or To	N (Street and Nu wn, State)	mber or Run	al Route Number,
item 2	L	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSIC	IAN: To the best of my kn	owiedge, death occurre	d at the time, d	ata and place, and due	to the causels) and manner as	eleted	
ANT: It	COMPL	2 MEDICAL EXAMINER								e(a) and manner as stated.
IMPORTANT: II	O BE	296. SIGNATURE AND TITLE OF CERTIFIER	meula) m.	A.	29c. LICENSE NUI D12642				ED (Month, Day, Year) 1 07,1995
	- 1	30. WAME AND ADDRESS OF PERSON WHO Fe U. Porciuncul				ania Ave	на	gerst	own -	MD 21742
		31. DATE FILED (Month, Dey, Year) APR 1 2 1995	REGISTRAR'S SIG		2		,			



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last 2. DATE OF DEATH 3. TIME OF DEATH 1995 April Lawrence Green 9:57 PM 4. SOCIAL SECURITY NUMBER S SEY 6. AGE (In vrs. lest birthday IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign (Month, Day, Year) May 28 68 1 X M 2 1 215-20-0485 Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Arundal Medical Center DIRECTOR Annapolis Anne Arundal RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Chester Riverside 1 - YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 211 Riverside Drive DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 21619 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried В 3 Wildowed 4 Divorced Illy45-August46 Alro-American 15. DECEDENT'S EDUCATION 6 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Waterman Self Employed at once. 17. FATNER'S NAME (First, Middle, Last)
William Green 18. MOTNER'S NAME (First, Middle, Maiden Surname) Lucille Smith BE notified 19a. INFORMANT'S NAME (Type/Print) and Number or Rural Route Number, City or Yown, State, Zip Code) 21619 9 Evelyn Green Riverside Drive Chester, Maryland hours after death. Page 6 may be Pe 20a. METNOD OF DISPOSITION

1 Burlal 2 Cremation 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 4 / 17/95 DATE 20c. LOCATION — City or Town, State must UMC Cemerty Chester, Maryland examiner 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1639 Broadway Jeff miller F/H P.C. 21213 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onsat and Daath disease or condition Acute Respiratory Obstruction
DUE TO (OR AS A CONSEQUENCE OF): event. resulting in death) Days Poor Swallowing Ability traumatic Month CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING Month other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Respiratory Arrest 0 4 Days PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 23 shows any 1 - YES 2 1 NO OF DEATN? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 12 NO 12 UNCERTAIN 12 PHYSICIAN: DR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER 1 TYES 2 NO g Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF marked. 28d. DESCRIBE HOW INJURY OCCURED 1 💢 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Nomicide TO THE HOSPITAL DR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If item 2 29a. CERTIFIER 1 🔀 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and pieca, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 4/24/95 9 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Annapolis Barbara L. Bean MD Suite 300 900 Bestgate Road, Maryland 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 26 1995

Davidson Rordall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

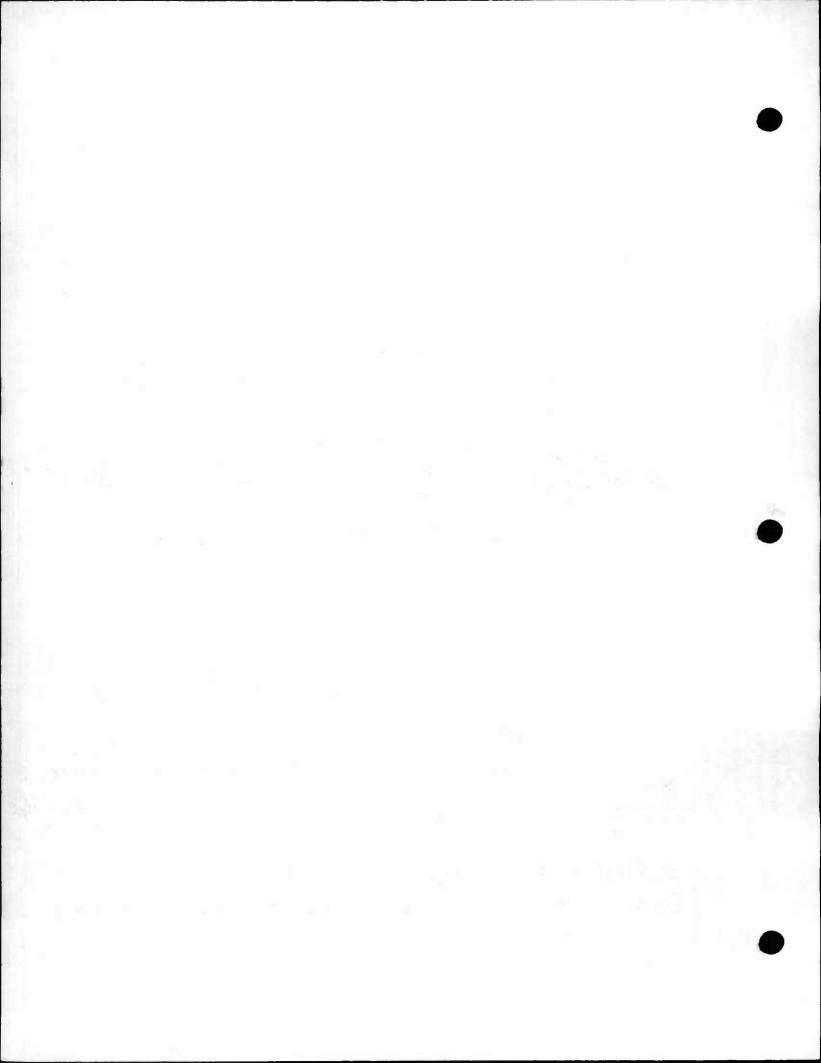
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTR
1. OECEOENT'S
ROB
4. SOCIAL SECU
577-90
9e. FACILITY NA
E/B B
RESIDENCE
10a. STATE
MD
10e. STREET AN

STATE OF MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	TH.		DEG NO

	REGISTRAR		CI	ERTIF	ICATE	OF	DEATH	REG. NO			
	1. OECEOENT'S NAME (First, Middle, Last)							2. DATE OF OEATH MONTH D	AY	YEAR	3. TIME OF OEATH
	ROBERT GEOR							APRIL 23	19	995	5:15P M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les	-	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 11 1	0.50	Count	
	577-90-0061 9e. FACILITY NAME (If not institution, give	1 X M 2 D F	36	YRS.							ansas
œ							OR LOCATION OF DI	EATH		NTY OF C	
61	E/B BAY BRIDG	<u>E</u>			50	<u>eve</u>	nsville		(QUEE	EN ANNES
DIRECTOR	10a. STATE 10b. COUNT	ry		10c. CIT	Y, TOWN O						10d. INSIDE CITY
		e Arundel			Pa	sade	ena				1 TYES 2 ANO
₹	10e. STREET AND NUMBER					10	f. ZIP CODE				WHAT COUNTRY?
FUNERAL	103 Willobrook D						21122			ited	States
5	11. MARITAL STATUS 1 Never Married 2 Merried		YES 2 2	NO MEO	1 1	f yes, sp	pecify Cuben, Maxica	NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No-	14. RACI Blac	E — American Indian, k, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR OATES		1	☐ YES	3 2 NO Specif	y:		Spec	
	15. OECEOENT'S EO	UCATION	16a. OE	CEOENT'S	USUAL OC	CUPATI	ON	16b, KINO OF BU	SINESS/INC	OUSTRY	
ы	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	life	ive kind of a Do NOT us	work done one retired.)	during mo	ost of working				
MPL	12	25		Mai	nager			Fo	od In	dusti	rv
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NA	ME (First, Middle, Maiden			
BE	Robert G. Gat	es, Sr.						ry f alia Hat			u
2	19e. INFORMANT'S NAME (Type/Print)		19					Route Number, City or Tow			
	Catherine M. Ga	tes						Pasadena,	Maryl	and	21122
	20e. METHOO OF OISPOSITION 1 Derial 2 Cremetion 3 Ren	noval from State	20b. PLACE /	matory or o	ther place)	TION (N	ame of	1	CATION —		The state of the s
1	4 Donation 5 Other (Specify)	Ensur 17	1 St. D	emet			netery 4/2		Annar	oolis,	Maryland
			1.1		22.1	A T	NO ADDRESS OF FA	John M.	Taylo	or F	uneral Home
_	23. PART I. Enter the diseases.	1.6	1					Bloucester			olis, MD
NO	IMMEDIATE CAUSE (Final disesse or condition resulting in death) Sequentially list conditions,	b	DRIAS A CONSEC			0	Clast 1	giures			Onsat and Daeth
CERTIFICATION	if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	c	OR AS A CONSE								
	PART ii. Other algnificant condition	ns contributing to	laath but not r	eaulting i	n tha un	deriyin	g cause given in	Part i. 24e. WAS AN		24b	. WERE AUTOPSY FINDINGS
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당	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	E OF OEAT							
Š	1XX ES 2 NO	1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER	l: ing Hom	ne 5 🗆 Residence	aX Wither (Specify) B	AY E	BRID	GE
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ĭ	1 Natural 5 Pending 2 Accident Investigation	3/26	195	209	43M	1 🗆 '	4	Subject 14	mbed	6H	Pridge
	3 Suloide 6 Could not be 4 Homicide determined	28e. PLACE OF building, e	INJURY — At ho Ic. (Specify)	me, larm, a	streel, lecto	ory, offic	• *\	281. LPCATION (Preet of Otty or Town, State)	Number	or Rural F	Route Number,
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COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICAL EXAMIN							to the ceuse(e) and mer time, date end place, en			Pary land o) and manner so stated.
	296, SIGNATURE AND TITLE OF CERTIFIE	R A	-				29c. LICENSE NUM	IBER	29d. OAT	E SIGNEO	(Month, Day, Year)
BE	Theodore	U. They	m				O.C.M	I.E			24,1995
유	30! NAME AND ADDRESS OF PERSON WI	O COMPLETEO CANS	OF OEATH (ITE	4 27) (Type,	Print)						
	31. OATE FILEO (Month, Day, Year)	32. REGISTRAR	111 'S SIGNATURE	Penr	st	ree	t, Balt	imore, M	ary]	and	21201
	APR 27 1995	Soli At	wilson Ra	dall							



YEAR 1995

9c COUNTY OF DEATH

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3. TIME OF DEATH

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10d. INSIDE CITY

14. RACE — American Indien, Black, White, atc.

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Interval Between

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24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

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Onset and Death

8. BIRTHPLACE (State or Foreign

MARYLAND

10g. CITIZEN OF WHAT COUNTRY?

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DIVISION OF VITAL RE

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)
APR 27 1995

2. DATE OF DEATH Giles April 100 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIFTIN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 215-12-9028 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH Hospita DIRECTOR ornie 10c CITY TOWN OR LOCATION MARYLAND ANNE ARUNDEL SEVERNA PARK permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE page 5 should be detached for use as the burial-transit 371 RITCHIE HIGHWAY 21146 the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

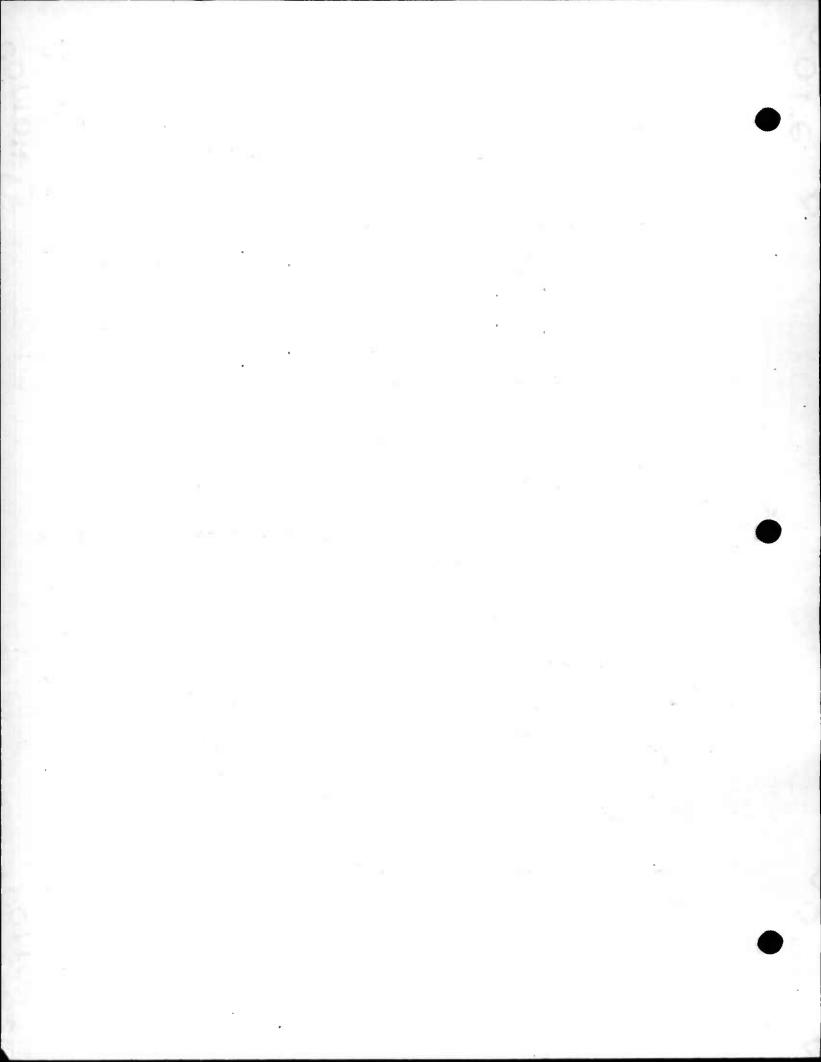
1 YES 2 NO Specify: 21215-0020 1 Never Married 2 Married BY 3 ♥ Widowed 4 □ Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp ANNE ARUNDEL COMMUNITY Elementary/Secondary (0-12) College (1-4 or 5 +) 7th CUSTODIAN COLLEGE 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) 76 CHARLES I. CARR BE ESTHER MORGAN notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 VIRGINIA WHITE BOX 11934 BALTIMORE, MD. 21207 2 e 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must funeral director, ASBURY TOWNNECK CHURCH CEME.4/29/95 SEVERNA PK., MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE REESE & SONS MORTUARY, P.A. ellian removal 821 WEST ST. ANNAPOLIS, MD. 21401 medical filled in by t 23. PART I. Enter the disesses, or complications that ceused the death. Do not sntar the mods of dying, such as cerdiec or respiratory street, shock, or heart failure. List only one cause on each line. , hemorrhage ŏ Suk arach IMMEDIATE CAUSE (Final cremation the disesse or condition resulting in desth) MASSIVE SHBDHRA-L pletely f EMATOMA event, DUE TO (OR AS A CONSEQUENCE OF): and com HYPERTENSION traumatic CERTIFICATION Sequentially list conditions, 9 DUE TO (OR AS A CONSEQUENCE OF) if sny, isading to immediate physician prior cause. Enter UNDERLYING CAUSE (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events aftending resulting in death) LAST Mental injury. signed by the a Health and Men PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY shows any 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSFITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Homa 5 Residence 8 Other (Specify) 6 the the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c Natural 5 Pending 1 YES 2 NO BY After t 2 Accident Investigation DIRECTOR: At hours after de item 28 is r 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 🗌 Homicide determined FUNERAL DIRECT WITHIN 72 hours a 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) end manner as stated. (Check only one) HOSPITAL TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: IN 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MADICAL D 4397 HOWSE OFFICER 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BURNIE ARLVE

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

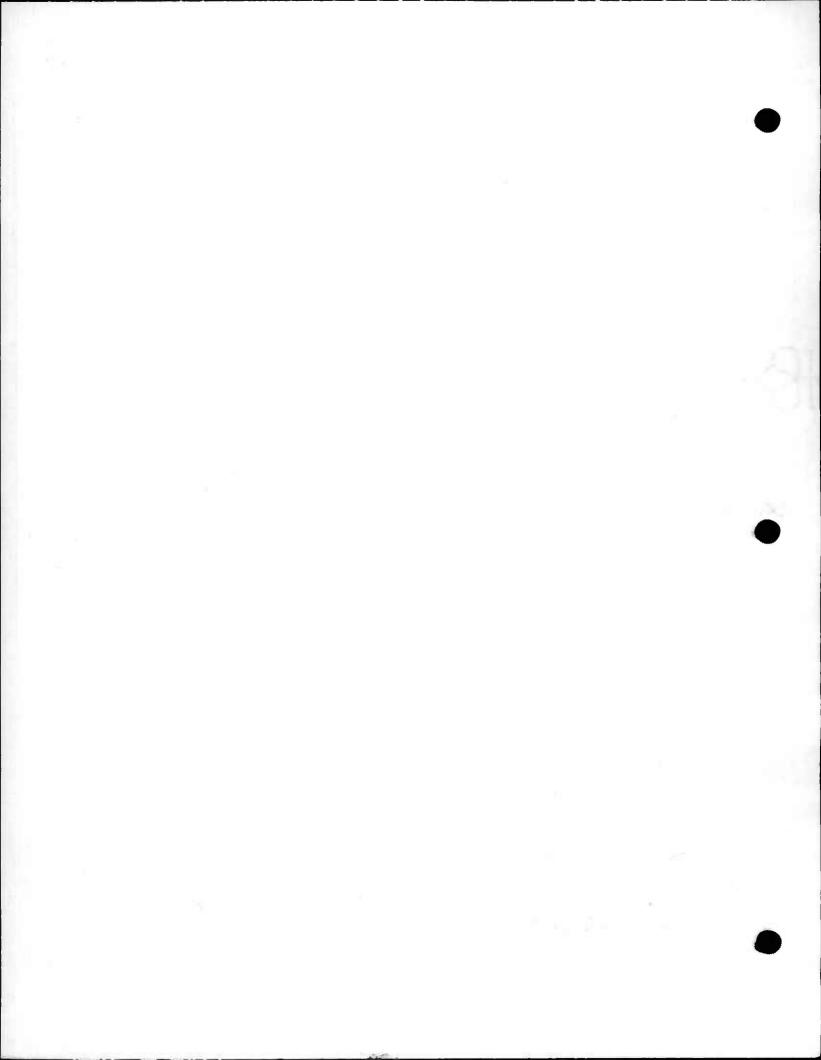
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	death. Page 6 may be retained by the hospital or attending physici
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BOX 68760	ate be executed with
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RECORDS, I	SICIAN; The law requires that the death certificate be executed with-
JIVISION OF VITAL	OR ATTENDING PHYSICIAN: The law
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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) Gertrude L			Gellatly			2. DATE OF DEATH MODICH 31, DAY 1995 YEAR 6:23P				
	579-18-4047	1 □ M 2 💢 F	GE (In yrs. last birthday	MONTHS DAYS		7. DATE OF B (Month, Den Jan. 1	y, Year)		BIRTHPLACE (State or Foreign Country) Maryland		
<u>~</u>	Se. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH			
65	Doctor's Community Hospital			Lanham				Prince George's			
DIRECTOR	Maryland Prince George's			city, town or location Greenbelt				10d. INSIDE CITY LIMITS? 1 X YES 2 \(\text{NO}\) NO			
FUNERAL	Contract the state of the state	10s. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN OF WNAT COUNTRY?		
N N	7010 Greenbelt Road 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED			20770			United States				
B	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	ES 2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specifi yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ YES 2 ※ NO Specify:			, etc.)	Vea or No— 14. RACE — American Indian, Black, White, atc. Specify: White			
TED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	(Give kind o	S USUAL OCCUPA work done during	TION most of working	16b. KIN	D OF BUSIN	BUSINESS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Adminis	22 0304	Assistan	t Ch	urch				
8	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden Surname)					
BE	Leroy M. Laughton		405 44411	O 4000000 (0:	Elizabe						
5	Ronald E. Gellatly								,		
	20a. METHOD OF DISPOSITION 20b. PLACE AND D			Berwyn Road, Berwyn Heig			20c. LOCAT	LOCATION — City or Town, Stata			
	1 M Buriel 2 Cremator 3 Removal from Stata 4 Donatton 5 Other (Specify) Fort Lincoln 21. SIGNATURE OF FUNERAL SERVICE LIDITSEE				In Cemetery 4/5/95 Brentwood, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Park a Very Signature of Funeral Service Licensee Fort Lincoln Funeral Home, I											
	1110-016	mplications that page	sed the death. Do	3401	Bladensb	urg Rd	., Br	entwo	ood, MD 20722		
	23. PART I. Enter the diseases, or complications that pused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Approximate interval Between Onset and Death										
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1	disesse or condition resulting in death) s.	Termina	l Cancer	of Live	7.						
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TION	resulting in death) s., Sequentially list conditions.		l Cancer s a consequence ancer wit s a consequence						Onset and Death		
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1 7 1	Sequentisity list conditions, if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions. Paroxysmal Atric DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO CAUSE DUE TO CAUSE DIPORTAL:	S A CONSEQUENCE To but not resulting action OF DEATH 28. PLACE OF DE purpetient 1 DOA 17 285. Till 28. PLACE OF DE purpetient 1 285. Till 28. PLACE OF DE purpetient 1 285. Till 28. PLACE OF DE purpetient 1 285. Till 28. PLACE OF DE purpetient 1 285. Till 285. T	In the underly	ng causa given in UNCERTAIN	1 [PERFORME YES 2 (1)	AO	Onset and Death 3 years 3 years 24b. Were autopsy findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 Yes 2 No		
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ificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

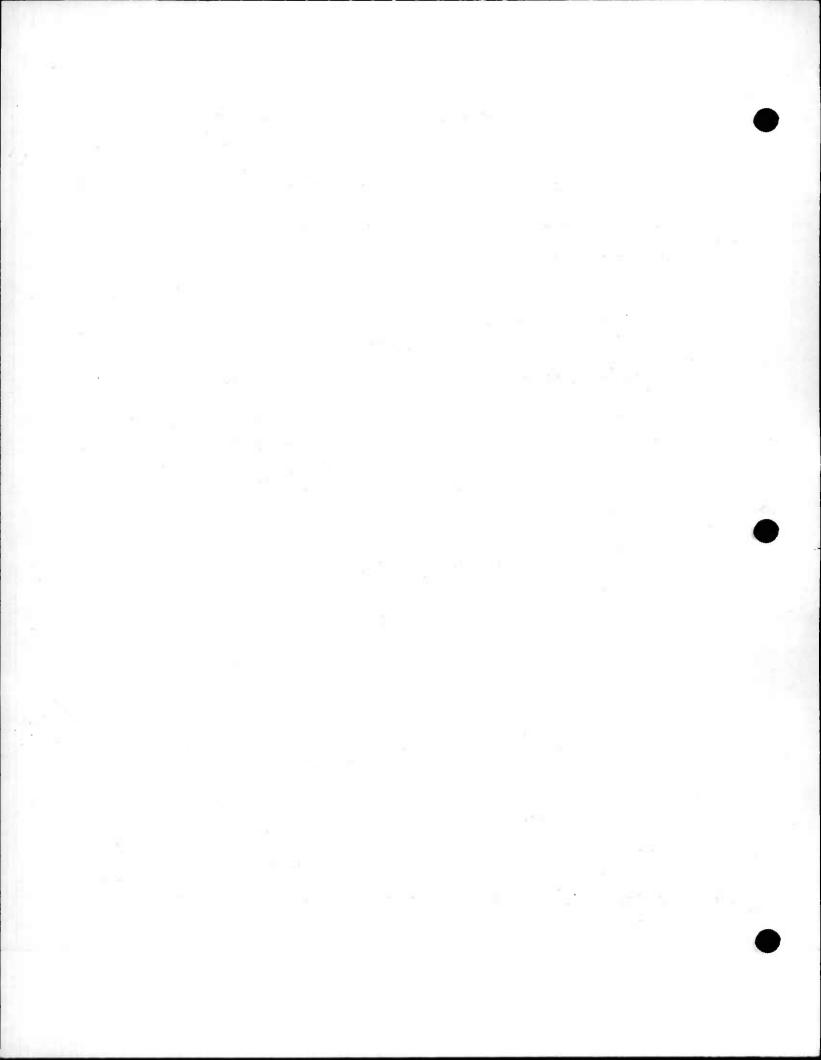
YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ertificate has been signed by the artending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within	TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely be fled within 72 hours with the Object of Health and Mental Hydiene prior to burial, cremating	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN		e.		
	1. DECEDENT'S NAME (First, Middle, Last)	lean	Gooding			2 DATE OF DEATH	3. TIME OF OEATH			
	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (h		IF UNDERNAME	IF UNDER 24 HMS.	DATE OF BIRTH (Morth, Day, Your)	8. B	IRTHPLACE (State or Foreign		
	577-64-2110 1 9a. FACILITY NAME (if not institution, give street	☐ M 2 🔯 F	48 YAS.	ONTHS DAYS	HOURS MIN.	June 24,	1946 Mi	ountry) Ssissippi		
OB	8623 Annapolis Road, #102 New Carroll									
띦	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY		
DIRECTOR	Maryland Prince	George's		New Car				LIMITS?		
AL	10a. STREET AND NUMBER			101	10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
Ä	8623 Annapolis Road, #102				20784			U.S.A.		
BY FUNERAL	11. MARITAL STATUS 1	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell 19 yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:			Black, White, atc. Specify:		
	15. DECEDENT'S EDUCATI	16a. DECEDENT'S U	SUAL OCCUPATION	DN .	185 KIND OF BUI	USINESS/INDUSTRY White				
COMPLETED	(Specify only highest grade corr Elementary/Secondary (0-12)	college (1-4 or 5+)	(Give kind of wo	rk done during mo retired.)	at of working			"		
AP.	10					Own Ho	lome			
Ö	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
BE (Louis Nichols				Doris	Jones				
TO E	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street a									
-	Betty Ajmani		6131 St	ımmer Pa	rk Lane	, Alexandr:	ia, Vir	ginia 22310		
	20a. METHOD OF DISPOSITION 1 ♣ Burlel 2 ☐ Cremation 3 ☐ Removal	from State ceme	PLACE AND DATE OF	er nlecel			CATION - City of			
	4 Donstion 6 Other (Specify) Fort Lincoln Cemetery 4/11/95 Brentwood, Maryland									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.									
	H Constance	e Base	ch	4739 E	Baltimore	e Ave. Hyat	tsvill	e. MD 20781		
CERTIFICATION	23. PART I. Enter the diseases, or complicational that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, above, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):									
MEDICAL C	PART II. Other eignificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 PHO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH?							AVAILABLE PRIOR TO		
M	1 VES 2 NO									
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
S		OSPITAL:		OTHER:						
¥	1 YES 2 NO 1	Inpatient 2 ER/Outpar 28s. DATE OF INJURY	tlent 3 OOA 4	Nursing Hom		6 Other (Specify)				
	1 Neturel 5 Pending	(Month, Day, Year)	INJUI	OW YF	RK7	28d. DEŞCRIBE HOW II	NJURY OCCURE	0		
B	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY	OF INJURY — Al home, farm, street, factory, office			28f. LOCATION (Street and Number or Bural Boute Number.				
TEO	4 Homicide datarmined	28 (y)			City or Town, State)					
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
BE	296 SIGNATURE AND TITLE OF CERTIFIER	2	nun		200 LICENSE NUI	WBER	29 DATE SIG	NED (Month, Day, Year)		
10	I Englisto J. E	, angug	MI		アンクト	230	Anni	8,1995		
	Adausto P. Roc	Adausto P. Rock Hue 2-MD, 5009 Ray burn Ct. Cy Sar. MI 20748								
	APR 13 1995 July d'Audient Randell									

See 13 350 g 260 81 - 12

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
		MEG. 140.

	_	1 - STATE REGISTRAR	STATE OF I	MARYLA	AND / DEPAR CERTIF	TMENT ICATE	OF H	DEAT	AND N	MENTAI	REG. NO.	E		
		1. OECEDENT'S NAME (First, Middle, Last)	Catheri	ne E.	Milste	ad G	rayb	eal		Apr.	of DEATH	1995	VEAD !	TIME OF DEATH 1:15A M
_		4. SOCIAL SECURITY NUMBER 231-68-4415	5. SEX	6. AGE (1)	n yrs. lest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Month)	OF BIRTH Cay, Years 12/48		Country) Washi	ngton, D.C
3 should	æ	Se. FACILITY NAME (If not institution, give a	treet end number)					OR LOCATIO				9c. COUNT	Y OF DEAT	Н
1, 2,	OT O	Holy Cross Hospit	al			Silver Spring							gomer	У
Pages	FUNERAL DIRECTOR	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN (OR LOCAT	ION					10	d. INSIDE CITY LIMITS?
permit. Pages		Maryland Princ 100. STREET AND NUMBER	e George	s	Upper Marlboro 1 1 D(Y v. 100, CITIZEN OF WHAT CO								YES 2 NO	
nsit p			Wav		20772 USA							EN OF WILE	COONTACT	
20 ysiciar yrial-tra	J.	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDEN	T EVER IN	U.S. ARMED	13.	WAS DEC		F HISPANI	C ORIGIN	? (Specify Yee		4. RACE	American Indian, hite, etc.
.AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once.	B	3 Widowed 4 Divorced	FORCES? 1 YES 2 NO				T YES		Specify:		income citaly		Spec#y: White	
215 attend	E	15. DECEDENT'S EDU (Specify only highest grade		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of					a	16b.	KIND OF BUS			
oital or of for a	LET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT u	e retired.)		or or worker		Ţ	J.S. P	ostal	Serv	ice
LAND the hospital the hospital detached to	COMPL	11th 17. FATHER'S NAME (First, Middle, Last)			Superv	isor		18. MOTH	FR'S NAL	AF (First A	fiddle, Maiden	Sumamal		
YL by th	ш	Richard W. Mi	1stead								Haves			
MAR: retained 15 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)						nd Number	or Rural A	oute Numb	er, City or Town	n, State, Zip C	,	
E, N ny be r page 5		Judy I. Savage	· · · · · · · · · · · · · · · · · · ·	1 001					Ct.		nantow			
OR ector, must		1 Burlel 2 Cremation 3 Rem 4 Donetion 5 Other (Specify)	oval from State	ceme	PLACE AND DATE etery, crematory or o etropoli	thar place)			, / ₁ /1	OATI		CATION - CI		
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic y the funeral director, page 5 should be detached for use as the burial noval. cal examiner must be notified at once.	1 7	21. SIGNATURE OF UNERAL, SERVICE LIC	1//	/1	200011	22.	NAME AN	D ADDRES	S OF FAC	ILITY			la, v	a
SAL er deat he fun al.		George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill Md. 20745 23. Paul Enter the diseases or complications that caused the desth. Do not anter the mode of dying, such as cardiac or reapiratory arrest, Approximate												
tely filled in bration, or rer		immediate Cause (Final disease or condition resulting in death)	Cardio	opu1m	the desth. Do inch line.	rrest		de of dyl	ng, such	ss card	iac or reapi	ratory arre	nt,	Approximate interval Between Onset and Death
BOX 68: icate be execute physician and co the prior to buria er traumatic	RTIFICATION	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A	Liver D consequence of	7):	se							
DS, P.O. the death certif the attending it Mental Hygier injury, or oth	CERTI	resulting in death) LAST												
RDS, P at the death by the atten and Mental I		PART N. Other aignificent condition	a contributing to	daath bu	it not resulting	n the un	deriying	ceuse g	iven in F	Part I.	24a. WAS AN . PERFOR			RE AUTOPSY FINDINGS
RECORD w requires that the been signed by th pt. of Health and I shows any in	MEDICAL									-	1 TYES 2		CO DF	MPLETION OF CAUSE DEATH? YES 2 NO
AL R he law re has beer b Dept. of n 23 sh		DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF	DEATH YE	S 🗆 1	10 X	UNC	ERTAIN					,
VITA NY: The ficate his State D	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL:		8. PLACE OF DEAT	OTHER	t:							
the the CC	НХ	27. MANNER OF DEATH	1XXInpatient 2 0	INJURY	28b. TIM	E OF	28c, INJL				(Specify) CRIBE HOW IN	JURY OCCU	RED	
NG PHYS frer this sath with	ВУР	1 Naturel 5 Pending 2 Accident Investigation	(Month, D	lay, Year)	INJ	URY	1 🔲 Y	RK? ES 2	_					
TISIC TTENDI TTOR: A after de		3 Suicide 8 Could not be determined	28e. PLACE O building,	F INJURY - atc. (Specif	At home, farm, a	treet, fact	ory, office	,		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
로 기가 느	COMPLET	290. CERTIFIER (Check only one) 2	CIMM To the bast of	my knowle	end/or investigation	nd at the ti	me, date	end plece,	end due 1	o the cou	se(e) end men	ner ee stated	ceuse(e) en	d menner ee stated.
THE HOS THE FUN filed with	BE C	29b. SIGNATURE AND TITLE OF CERTIFIES		/ -					NSE NUME					nth, Day, Year)
THE HOSPIT THE FUNERA The Mithin 7	TO B	(Sernecas	jonk	ins				D399	73				6/95	
(in)		Veronica Jenkins,	M.D. 610	04 01	d Branch		e. Te	emp1e	Hi1	ls,	Md. 20			
9		APR 10 1995	JE REGISTRA	R'S SIGNA	Rerdall									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR			ICATE (REG									
1 3	1. DECEDENT'S NAME (First, Middle, Last)		el Cathe	rine G	ıde)	2. DATE OF DEA	TN DAY	YEAR 3. TIME (F DEATN						
1	Catherine Mab	el Gude				April		995 6:0	0 P M						
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YE		7. DATE OF BIRT	N	8. BIRTNPLACE (St							
	220-56-6613	1 M 2 X F	90 YRS.	MONTHS DA	YS HOURS MIN.	Jan. 30		Marylan	1						
	9e. FACILITY NAME (If not institution, give :	street and number)		9b. CITY, TO	WN OR LOCATION OF D			INTY OF DEATH							
S	Carriage Hill N	ursing Center	•	Silve	Silver Spring Montgom										
5	RESIDENCE OF DECEDENT			DIIV	or Spring		Mol	regomery							
DIRECTOR	10a. STATE 10b. COUNT	•	10c. CIT	Y, TOWN OR L	DCATION			10d, INSH	E CITY						
		ce George's		Adel	hi		LIMI 1 🖾 YES								
₹	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CIT	IZEN OF WHAT COU	ITRY?						
<u> </u>	1722 Keokee Stre	eet			20783		U.S	5.A.							
BY FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS	DECENDENT OF NISPA	NIC ORIGIN? (Speci	fy Yes or No-	14. RACE — Americ	en Indien,						
>	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			I, specify Cuben, Mexico YES 2 🔯 NO Specif		c.)	Black, White, at Specify:	C.						
					77.54			Whit	e						
E	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S (Give kind of	work done durin	PATION g most of working	16b. KIND O	F BUSINESS/IN	DUSTRY							
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT u	se retired.)		- 1									
₽ I	6		Homema	iker		0	wn Home	9							
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, M	elden Sumeme)								
BE		Charles			Mary	Eleanor									
2	19e. INFORMANT'S NAME (Type/Print)				eet end Number or Rural										
-	Betty F. Radisch	1	1722 K	Ceokee	Street, Ad	delphi,	Marylan	d 20783							
	20e. METNOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rem	20b	PLACE AND DATE	OF DISPOSITIO	N (Name of	DATE 20	c. LOCATION —	City or Town, State							
	4 Donation 5 Other (Specify)	Ro	ock Creek	c Cemet	ery 4/	11/95 W	ashingt	ton, D.C.							
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAM	E AND ADDRESS OF FA	CILITY									
	►71 1 t	Y		Fran	cis Gasch	s Sons	Funeral	Home, P	Α.						
_	A Consia	nel Na	seh	4739	Baltimore	e Ave.,H	yattsvi	lle, MD	20781						
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications that caused Liat only one cause on e	the death. Do i	not enter the	mode of dying, suc	h as cardiac or	reapiratory ar		roximata						
	IMMEDIATE CAUSE (Final	/3 1	11	1 -	0				rval Batween et and Death						
	disease or condition reaulting in death)	Congestin	e Hear	t Fau	lure			1.4	SAYC						
İ		DUE TO (OR AS A	CONSEQUENCE O	F):											
Z	Convention lies on distance	b													
\geq \parallel	if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):											
Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):															
CAT	CAUSE (Disease or Injury														
LIFICAT	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE O	F):	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
ERTIFICAT	CAUSE (Disease or Injury	cDUE TO (OR AS A	CONSEQUENCE O	F):											
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	d													
CAL CERTIFICAT	CAUSE (Disease or Injury that initiated events	d			ying cause given in		S AN AUTOPSY	24b. WERE AUTI	PRIOR TO						
DICAL CERTIFICAT	CAUSE (Disease or injury that initiated events resulting in death) LAST	d			ying cause given in	PE		AVAILABLE	PRIOR TO ON OF CAUSE						
MEDICAL CERTIFICAT	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition	da contributing to death b	ut not resulting	in the under		PE	RFORMED?	AVAILABLE	PRIOR TO ON OF CAUSE						
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	da contributing to death b	ut not resulting	in the under		1 YI	RFORMED?	AVAILABLE COMPLETE OF DEATH	PRIOR TO ON OF CAUSE						
MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONTI	d. a contributing to death b	ut not resulting	In the under	UNCERTAI	1 YI	RFORMED?	AVAILABLE COMPLETE OF DEATH	PRIOR TO ON OF CAUSE						
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONTI	d. na contributing to death b	F DEATH YE	In the under	UNCERTAII	1 YI	RFORMED?	AVAILABLE COMPLETE OF DEATH	PRIOR TO ON OF CAUSE						
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONTI	RIBUTE TO CAUSE O HOSPITAL: 1 Inpatient 2 ER/Outp	F DEATH YE 28. PLACE OF DEA: etient 3 DOA	In the under	UNCERTAII	1 YI	RFORMED?	AMAILABLE COMPLETM OF DEATH 1 YES	PRIOR TO ON OF CAUSE						
PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending	RIBUTE TO CAUSE O	F DEATH YE 28. PLACE OF DEA: etient 3 DOA	In the under	UNCERTAIN	PE 1 YI	RFORMED?	AMAILABLE COMPLETM OF DEATH 1 YES	PRIOR TO ON OF CAUSE						
BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation	RIBUTE TO CAUSE O HOSPITAL: 1 inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	F DEATH YE 26. PLACE OF DEA 28b. TIM	In the under	UNCERTAIN One) Nome 5 Residence INJURY AT WORK? YES 2 NO	PE 1 YI 6 Other (Specify 28d. DESCRIBE N	RFORMED? ES 2 NO OWINJURY OC	AMAILABLE COMPLETI OF DEATH' 1 YES	PRIOR TO ON OF CAUSE						
BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation	RIBUTE TO CAUSE O HOSPITAL: 1 Inpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	F DEATH YE 26. PLACE OF DEA 28b. TIM	In the under	UNCERTAIN One) Nome 5 Residence INJURY AT WORK? YES 2 NO	PE 1 YI 6 Other (Specify 28d. DESCRIBE N	RFORMED? ES 2 NO OW INJURY Octated and Number	AMAILABLE COMPLETM OF DEATH 1 YES	PRIOR TO ON OF CAUSE						
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BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PNYSI	RIBUTE TO CAUSE O HOSPITAL: 1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec	F DEATH YE 26. PLACE OF DEATH attent 3 DOA 28b. TIM (iv) At home, farm, in	In the under	UNCERTAIN One) Nome 5 Residence INJURY AT WORK? YES 2 NO office	5 Other (Specify) 28d. DESCRIBE N 28t. LOCATION (S Cify or Town, s)	PRORMED? ES 2 NO OW INJURY OC treet end Number State) d manner ee atar	AWAILABLE COMPLIE OF DEATH 1 YES CURED or Rural Route Numbe	PRIOR TO N OF CAUSE 2 NO						
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E COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Ves 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	RIBUTE TO CAUSE O HOSPITAL: 1 inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec	F DEATH YE 26. PLACE OF DEA atlent 3 DOA 28b. TIM (HV) At home, farm, to edge, death occurre o end/or investigation	In the under	UNCERTAIN One) Nome 5 Residence INJURY AT WORK? YES 2 NO office dete end place, end due n, death occured at the	6 Other (Specify) 28d. DESCRIBE N 28t. LOCATION (S City or Town, to the cause(e) end	RFORMED? ES 2 NO OW INJURY OCCUPANT OC	AWAILABLE COMPLETI OF DEATH' 1	PRIOR TO ON OF CAUSE 2 NO NO or ee stated.						
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full will of the profession

MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARY	(LAND / DEPAI	RTMENT OF H	EALTH AND I	MENTAL HYGIEN	E	10021
	1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE OF	DEATH	REG. NO		
	SOL	S.	GLTC	KSMAN		MONTH D		S. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		iE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	April 16,		2:54 P M BIRTHPLACE (State or Foreign
	100-07-6443 Se. FACILITY NAME (If not Institution, give s	1 🕅 M 2 🗆 F	83 YRS.	MONTHS DAYS	HOURS MIN.	Nov.16,1	911	Poland
DIRECTOR	Memorial Hospi			- N	or Location of DE	ATH	9c. COUNTY	egany
E I	10e. STATE 10b. COUNTY	,	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
L DIF	Maryland All	egany	c	umber la	n d		LIMITS?	
NERA	16 N. Allegany			10	21502		U.S	OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Vidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	If yes, sp	CENDENT OF HISPAN secify Cuben, Mexices 2 7 NO Specify	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	RACE — American Indian, Black, White, etc. Specify: White	
8	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUS	
COMPLETED	(Specify only highest grade	College (1-4 or 5+)	(Give kind of life. Do NOT u		ost of working			t Factory
M	Unknown 17. FATHER'S NAME (First, Middle, Lest)		Tiana	901				t ractory
BE C	Aron David Gli	cksman			Tauba	ME (First, Middle, Msiden		
5	190. INFORMANT'S NAME (Type/Print) Frances Glicksi	nan	19b. MAILING 16 N	. Alleg	nnd Number or Rural R Jany St-	oute Number, City or Tow Cumberla	n, State, Zip Coo	D 21502
	20e, METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Remote Control Burlel 2 Cremetion 3 Remote Control Burlel Bur	oval from State	Ob. PLACE AND DATE emetery, cremetory or of Eastviev	ther place)	4	411010 -		or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIC		Lastviev	22. NAME AL	ND ADDRESS OF FAC	OIL ITY		rland,MD
	tend of	Lochusel		Georg 202 G	le-Upchu Greene S	ırch Fune St.,Cumbe	ral H rland	ome,P.A. ,MD 21502
	23. PART I. Enter the disesses, or o shock, or heart fellure.	emplications that caus	ed the dasth. Do	not antar the mo	de of dying, such	ss cardisc or respi	ratory errest	Approximats
	IMMEDIATE CAUSE (Final	Liet Only One Cease On	eech line.					Interval Between Onset and Death
	disease or condition resulting in death)	Congesti	ve Heart	Failure				5 Years
	20=07447412	DUE TO (OR AS	A CONSEQUENCE O	F):				5 16615
N	Sequentially list conditions,	Renal Fa						4 Years
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING		A CONSEQUENCE O					
일	CAUSE (Disesse or Injury	in	Artery D					10 Years
Ē	that initiated events resulting in death) LAST	DOE TO (ON AS	A CONSEQUENCE O	r):				
8		ł						
7	PART II. Other algoriticent condition Diabetes Mell:		but not resulting	in the underlying	g ceuse given in i	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 YES 2	DANO.	DF DEATH?
ž	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YE	S NO C	UNCERTAIN	1 🔯		TES Z M NO
K	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA					
S	1 TES 2 NO	HOSPITAL:	ripatient 3 DOA	OTHER: 4 Nursing Hom	e 5 - Residence (6 Other (Specify)		
Y PHYSICIAN: MEDICA	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)		E OF 28c. INJ	URY AT	28d. DESCRIBE HOW I	JURY OCCURE	ED
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJUI building, atc. (Sp	RY — At home, farm, specify)			26f. LOCATION (Street e City or Town, Stete)	nd Number or F	tural Route Number,
						_ = = =		
COMPLETED	(Check only	CIAN: To the best of my knk R: On the basis of examinat	owledge, death occurre	n, in my opinion, d	end piece, end due t	to the ceuse(e) end men	ner ee atated.	use(e) end manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	0/ //			29c. LICENSE NUM			
#	11. /2	tt //	M	0	D 367		A A	ONED (Month, Day, Year)

Cumberland,

21502

MD

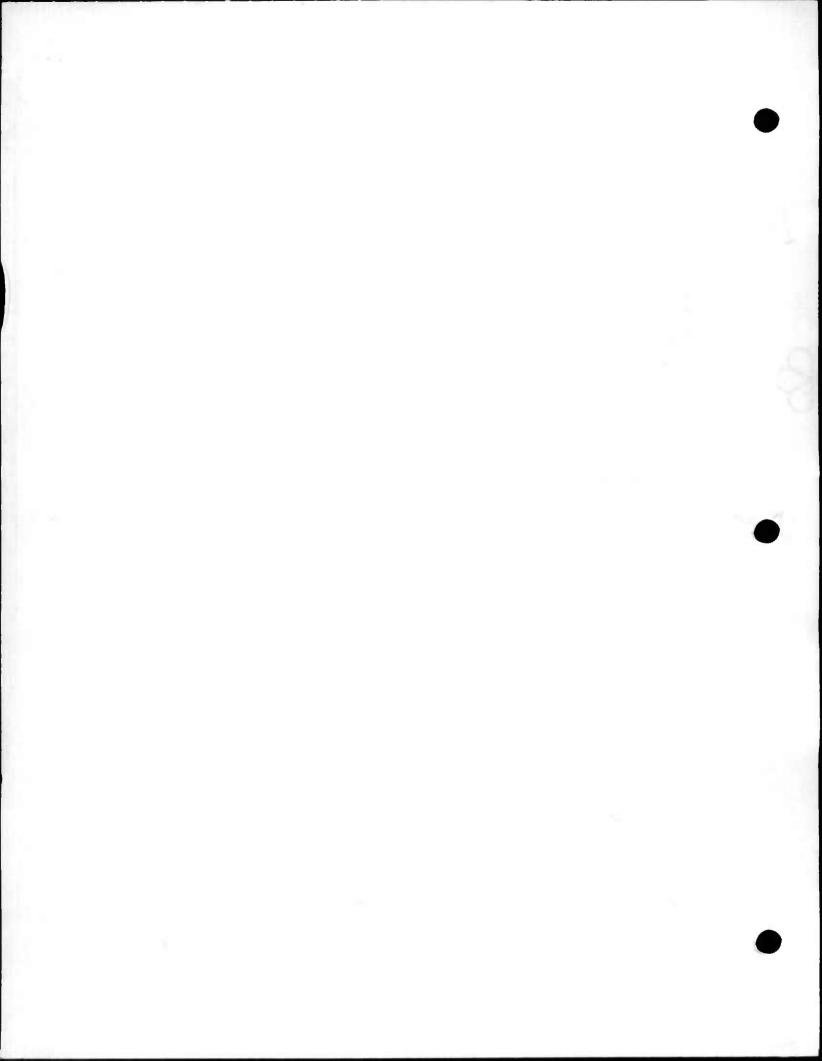
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

955

Frederick Street,

Dr. Vik Poonai

Dr.

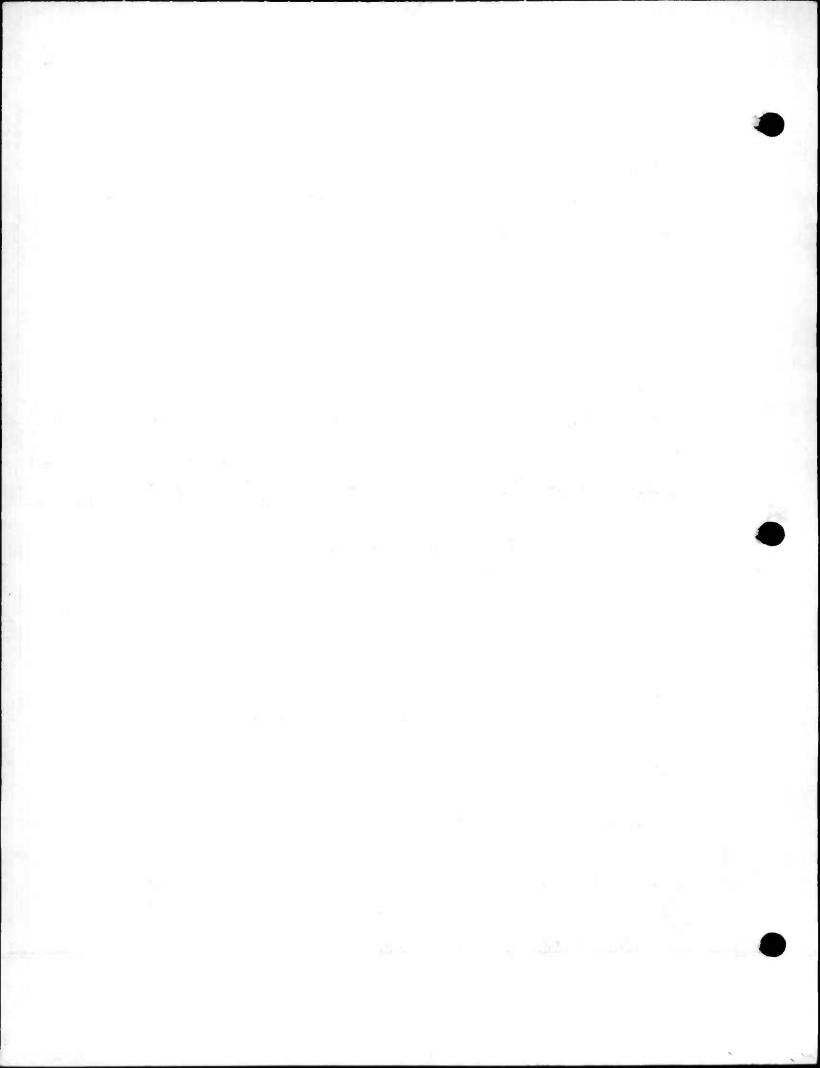


SBALTIMORE, MARYLAND 21215-0020	et hours after death. Page 6 may be retained by the hospital or attending physici	filled in by the funeral director, page 5 should be detached for use as the burial-
DIVISION OF VITAL RECORDS, P.O. BOX 68760, SALTIMORE, MARYLAND 21215-0020	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physicia	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to

trending physician. e as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within X frours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

214-52-6891 1 M 2 X 76 YRS. MONTHS DAYS HOURS MIN. (MONTH, Dey, Year) May 6, 1918	3:05 P. M IRTHPLACE (State or Foreign ountry) Texas
1. DECEDENT'S NAME (First, Middle, Last) TOUISE GTILIARD ADTI 22, 1995 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 1 M 2 X F 76 YRS. DAYS HOURS MIN. MAY 6, 1918	RTHPLACE (State or Foreign ountry) Texas
1 1 1 1 1 1 1 1 1 1	3:05 P. M IRTHPLACE (State or Foreign ountry) Texas
214-52-6891 1 M 2 X F 76 YRS. MONTHS DAYS HOURS MIN. May 6, 1918	Texas
214-52-6891 1 N 2 X 76 YRS. May 6, 1918	Texas
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY O	
Asbury Village Gaithersburg Montgo	omery
Asbury Village Gaithersburg Montgo	10d, INSIDE CITY
Maryland Montgomery Gaithersburg	LIMITS?
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN C	OF WHAT COUNTRY?
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN CO 20877 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. Respective Cuber. Market Plants Bloom etc.) 15. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. Respective Cuber. Market Plants Bloom etc.)	ı.s.a.
11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. R 14. R 16. Never Married 2 Married 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. R 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. R 19. Never Married 2 Married 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. R 19. Never Married 2 Married 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. R 19. Never Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2	RACE — American Indian, Black, White, etc.
	White
15. DECEDENT'S EDUCATION 166. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTR	
(Specify only highest grade completed) (Glve kind of work done during most of working life. Do NOT use retired.)	44
4 Homemaker Own Home	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker 18. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working life, Do NOT use retired.) OWN Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame)	
William Knowles Gertrude Miller	
196. IMPORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gary B. Gillard Ioli Bawnview Brive, Frederick, Farly	land 21701
20a. METHOD OF DISPOSITION 1	or Town, State
1 Donation 5 Other (Specify) Parkview Compt ory April 27, 1995 Rockvi	lle, Maryland
MOOO21 Reeney and Basford Funeral Ho	
23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reenistary errest	Approximata
shock, Dr heart feliure. List Dnly Dne ceuse Dn each lina.	interval Between Onset and Death
disease or condition a. Ischemic heart disease Due to (or as a consequence of):	Years
Afternational to the line of	No o of
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	Years Years
S cause. Enter UNDERLYING CAUSE (Disease or injury cause.	Years
that initiated events DUE TO (OR AS A CONSEQUENCE OF):	
resulting in death) LAST	
PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY	24b, WERE AUTOPSY FINDINGS
S Chronic (LAA) feilure	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Depression 1 YES 2 DANO	DF DEATH?
E Spinal Stanosis Tobacco played no role in death	1 153 2 18 40
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	
SPING STENDS TO BOLCED PLAYED TO BE IN JURY AT WORK? SPING STENDS TO BOLCED PLAYED TO BE IN JURY OF THE PLAYED TO BE IN JURY OF THE PLAYED TO BE IN JURY OF THE PLAYED TO BE IN JURY OF THE PLAYED TO BE IN JURY OF THE PLAYED TO BE IN JURY AT WORK? SPING STENDS TO BE IN JURY AT WORK? SPING STENDS TO BE IN JURY AT WORK?	
	0
2 Accident investigation M 1 YES 2 ND	
3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)	ral Route Number,
29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(a) and menner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the ceuse.	se(a) and manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGN	NED (Month, Day, Year)
Byl D. Johnson M.O. D-19042 April	23, 1995
BYRL D. JOHNSON 911 Russell Avenue Gaithersburg Maryland 20:	879
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE APR 2 8 1995 Julia Dhublar Realette	
MIN NO 1933 Comment of the comment	DHMH-16 Rev 1/89

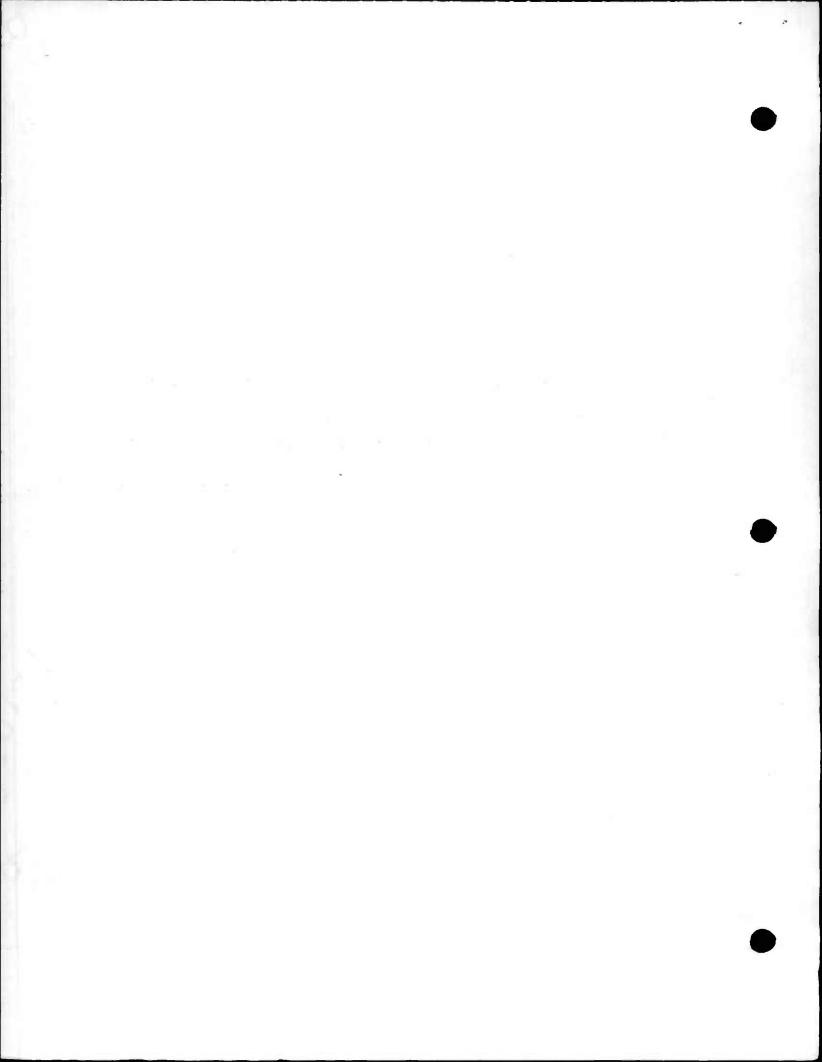


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death, Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Policy after this catelled with the State beg; of Health and Mental Hyglene prior to burial, cremation, or removal.	Marking I. Print J. St. Co. Co. Co. Co. Co. Co. Co. Co. Co. Co
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						MENTAL HYGIE		10020
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) MAYZCAY2E7 CATTSL		CERTIF	ICATE O	F DEATH	2. DATE OF DEATH MONTH	DAY	3. TIME OF DEATH
								95 5 PM
	219-30-6435 1 M 2 X F	6. AGE (In yr	s. lest birthday)	F UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland
_	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOW	N OR LOCATION OF E	EATH	9c. COUNT	Y OF DEATH
STOR	ST. MARCH'S HOSPITAL RESIDENCE OF DECEDENT			LEUNAR	22000 1	w)	57.	MARYS
DIRECTOR	10a. STATE 10b. COUNTY ST. MA	mus		Y, TOWN OR LO A WENUE				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 4776 HELLEY FARM		10f. ZIP CODE	0665	109. CITIZE	N OF WHAT COUNTRY?		
Z.		ENT EVER IN U.S	ARMED	12 WAS I		NIC ORIGIN? (Specify Y	Sec. 11.	
BY	1 Never Married 2 Married FORCES?	1 YES 2 WAR OR DATES	₩ NO	If yes,	specify Cuban, Maxic ES 2 NO Speci	an, Puarlo Rican, etc.)	ea or No 1	4. RACE — American Indian, Black, White, atc. Specify:
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or		(Give kind of a life. Do NOT us	USUAL OCCUPY work done during se retired.)	ATION most of working	16b. KIND OF B	USINESS/INDUS	STRY
ם	12		Homemal	ker		Own 1	Home	
ő	17. FATHER'S NAME (First, Middle, Last)				18, MOTHER'S N.	AME (First, Middle, Maide	n Sumame)	
BE C	Charles Heddinger				Marga	ret 1	unknowr	1
	19e, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Floute Number, City or To		
5	Earl G. Gable		ı			enue MD 2		
	20a. METHOD OF DISPOSITION 1 (X Burlet 2 Cremellon 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLA	CEANDDATE	OF DISPOSITION	(Nume of	DATE 20c. L	OCATION - CIT	y or Town, State Sville, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1 010	es crawi		AND ADDRESS OF F		LITOCUS	sviite, In
	Itanley M. Low	mer		Harr	y H Witzk	e Funeral		inc ott City,21043
	23. PART i. Enter the diegaea, or complications t	hat causad the	e death. Do r	ot antar the	mode of dylng, su	ch as cardiac pr res	piratory arres	t, Approximata
	ahock, or heert fallure. List only one of IMMEDIATE CAUSE (Final	EUMONI	line.					interval Between Onaet end Death
	recurring in decitif	TO (OR AS A COI		n.				16days
_		redio pu			aëst.			16day
CERTIFICATION	Sequentially list appditions	O (OR AS A CO						
윤	CAUSE (Disease or Injury C.	O (OR AS A CO	NSEQUENCE OF	n.				
ITH	resulting in death) LAST			,				
5	PART II Other significant conditions contribution	o death had a						
MEDICAL	PART II. Other algorificant conditions contributing ORGINIC BRIDE MUI		ot resulting i	n the underly	ing cause given in		PRMED?	24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: M	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF D	EATH YE	S 🗆 NO	☑ UNCERTAI	N D		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. F	PLACE OF DEAT	'H (Check only or	10)			
Š	1 YES 2 NO 1 Inpetiant 2	☐ ER/Outpatian	nt 3 🗆 DOA	OTHER: 4 Nursing H	oma 5 🗆 Raeldenca	6 Other (Specify)		
E	27. MANNER OF DEATH 28a. DATE (Month	De INJURY Day, Year)	26b. TIMI	E OF 28c. I	NJURY AT WORK?	26d. DESCRIBE HOW	INJURY OCCUI	RED
BY 1	1 Netural 5 Pending 2 Accident Investigation	//			YES 2 NO	160		
ETED E	3 Suicide 28a. PLACE	OF INJURY — A g, atc. (Specify)	t home, farm, s	strael, factory, of	fica	28t. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
COMPLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best one) 2 MEDICAL EXAMINER: On the best of							
EC	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IGNED (Month, Day, Year)
0	Thum	÷			D345			24195
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA		(ITEM 27) (Type	Print)	1 00 -13		4	7170
	171	_	667		en (a 1	4101 12	-A. (A 2 23)	02 10 h and 100.

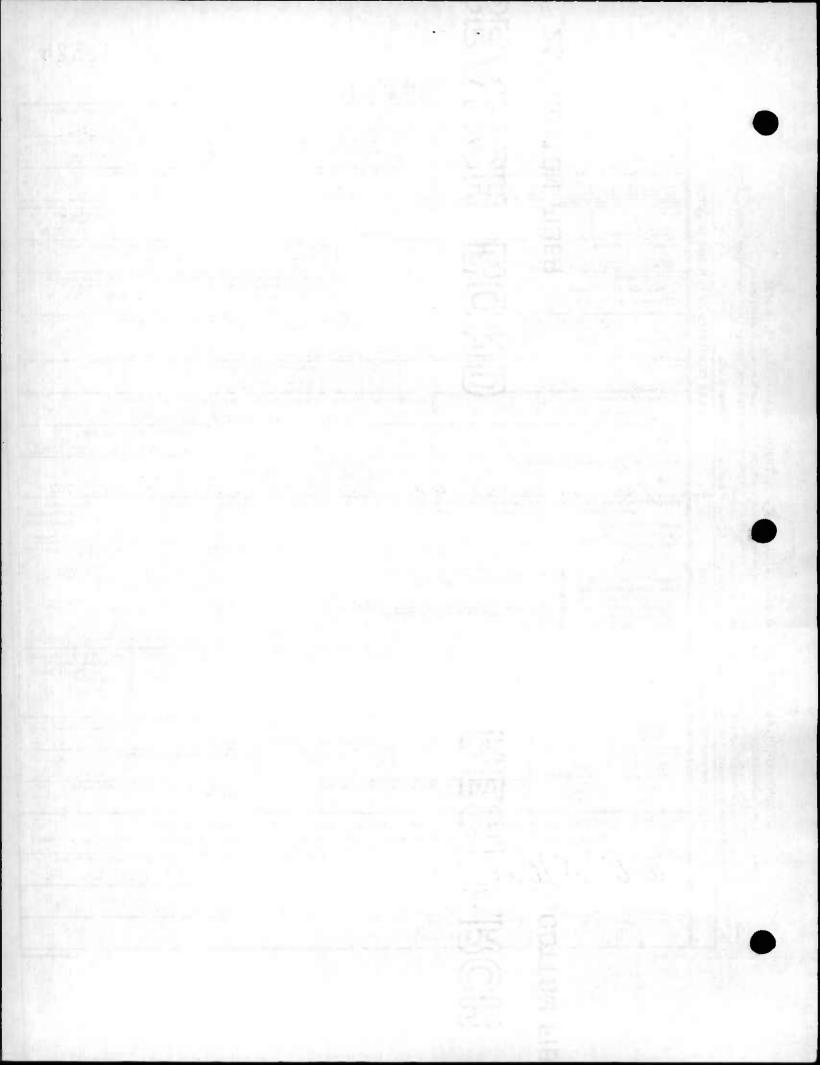
32, REGISTRAR'S SIGNATURE

APR 2 7 1995



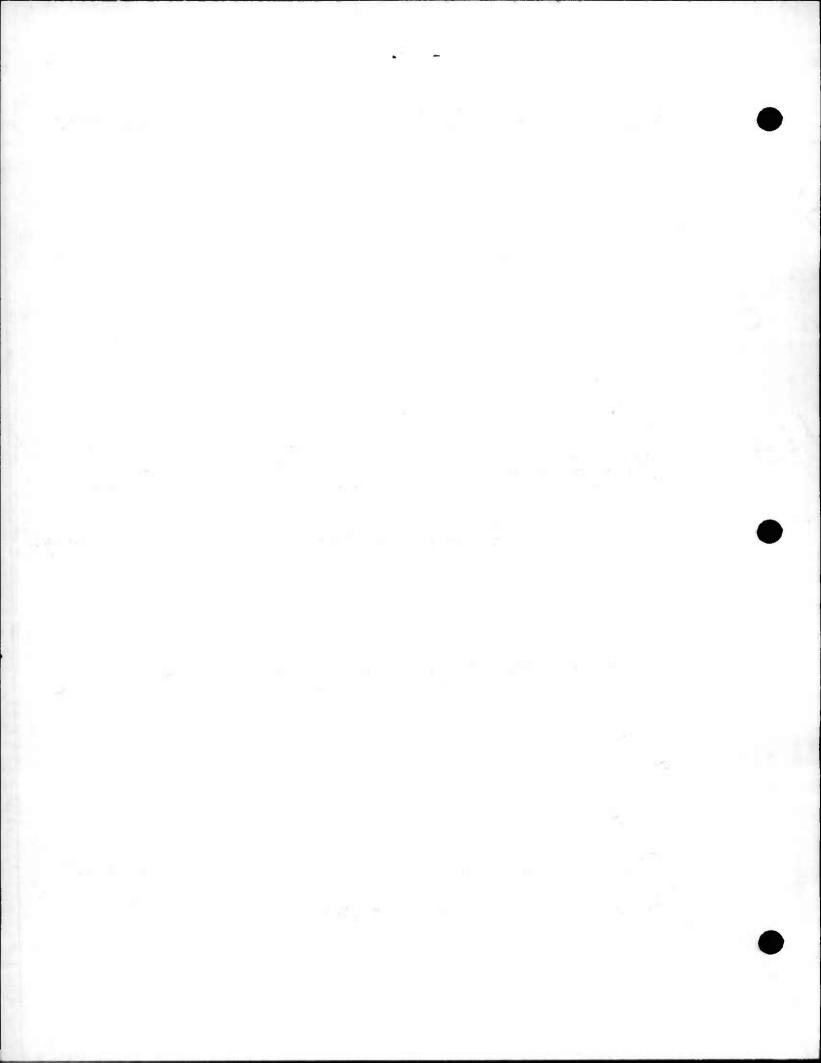
DHMH-16 Rev 1/89

	REGISTRAR 1. DECEDENT'S NAME (First, Middle,	(ast)	CERTIFIC	CAIL OF	DEATH	2 0.75	REG. NO.	100	3, TIME OF DEAT		
1	1. DEGEDENT S NAME (F 10), MICCOS,		izabeth Gi	ddings		Apr		, 1995	3. TIME OF DEAT		
	4. SOCIAL SECURITY NUMBER 220 - 12 - 379			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH	915	BIRTHPLACE (State or For Country) Maryland		
OR	96. FACILITY NAME (If not institution, Laurel Regions	al Hospital		% city, town of Laurel	R LOCATION OF D	EATH		9c. COUNTY Princ	of DEATH ce George		
DIRECTOR		ounty Dward		TOWN OR LOCAT	ION	-			10d. INSIDE CITY LIMITS? 1 YES 2 (X)		
FUNERAL	100. STREET AND NUMBER 9841 Robinson			101.	. ZIP CODE 0723		312	N OF WHAT COUNTRY?			
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER	S 2 NO	13. WAS DEC		Black, White, atc. Specify:					
LETED	15. DECEOENT" (Specify only highest Elementary/Secondary (0-12)		16a. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo:	ON st of working		KIND OF BUSI				
COMP	Grade 10 17. FATHER'S NAME (First, Middle, La	st)	Owner -	Operat	18. MOTHER'S NA		Grocery Middle, Malden S		re		
BE	Spencer Giddir		10h MAII INO 4	DDDESS (Standard	Mary Du			Onto The C	40		
5	Mary Boyce	,			Blvd.,						
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 C 4 Donation 5 Other (Specify,	Removal from Stats	20b. PLACE AND DATE OF DISPOSITION (Name of cemelery, cremetory or other place) Emmanuel Cemetery 4/22 Scaggsville								
examiner must	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland										
	Laure	e Danie	Sear led the death Do no	Donal 313 T	dson Fur albott <i>F</i>	neral Ave.	Laurel	, Mary			
	23. PART I. Enter-the disease	a, or complications that cause on liure. List only one cause on a. Septicem.	aach line.	Donal 313 T	dson Fur albott <i>F</i>	neral Ave.	Laurel	, Mary			
ERTIFICATION	23. PART I. Enter the diseases abock, or heart fail IMMEDIATE CAUSE (Finel disease or condition	a, or complications that cause illure. List only one cause on a. Septicem DUE TO (OR AS DUE TO (OR AS C. Arteriose	ia	Donal 313 T ot enter the model inia :	dson Fur albott A de of dying, suc	neral Ave. I	Laurel	, Mary	Approxim Interval B Onset and		
MEDICAL CERTIFICATION	23. PART I. Enter the diseases shock, or heart fail immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a, or complications that cause illure. List only one cause on a. Septicem DUE TO (OR AS DUE TO (OR A	ia ia s a consequence of) on Pneumon s a consequence of) clerotic C s a consequence of)	Donal 313 T ot enter the model aia Cerebrov	dson Fur albott F de of dying, suc ascular	neral Ave. I ch as cand	Laurel	, Mary atory arrest	days		
MEDICAL	23. PART I. Enter the diseases shock, or heart fall immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	a, or complications that cause incre. List only one cause on a. Septicem. DUE TO (OR AS DUE TO (OR	ia s a consequence of) on Pneumon s a consequence of); cleratic C s a consequence of); but not resulting in	Donal 313 T ot entar the model aia Cerebrov the underlying	dson Fur albott F de of dying, suc ascular	Dise	Laurel liac or reapire 24a. WAS AN A PERFORM 1 YES 2 (, Mary atory arrest	Approximinterval B Onset and minut days years 24b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION DE G OF DEATH?		
SICIAN: MEDICAL	23. PART I. Enter the disease ahock, or heart fall immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	a, or complications that cause on liure. List only one cause on a Septicem. DUE TO (OR AS DUE TO (O	ia s a consequence of) on Pneumon s a consequence of) clerotic C s a consequence of) but not resulting in	Donal 313 T ot entar the model in the underlying the underlying 26. PL OTHER: 4 Nursing Home	dson Fur albott A de of dying, suc ascular g cause given in ACE OF DEATH (C)	Dise	Laurel liac or reapire 24a. WAS AN A PERFORM 1 YES 2 (, Mary atory arrest	Approximintarval B Onset and minut days years 24b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION DF (OF DEATH? 1 YES 2 1		
PHYSICIAN: MEDICAL	23. PART I. Enter the disease ahock, or heart fall immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	a, or complications that cause incre. List only one cause on a. Septicem. B. Aspiration Due to (or as the control of the cont	ia ia s a consequence of) on Pneumon s a consequence of) cleratic C s a consequence of) but not resulting in utpatient 3 DOA y 286. Time	Donal 313 T of entar the model in the underlying the underlying the underlying 26. PL OTHER: 4 Nursing Homeloof RY 28c. INLINE WO	dson Fur albott A de of dying, suc ascular g cause given in ACE OF DEATH (C)	Dise	Laurel liac or reapire 24a. WAS AN A PERFORM 1 YES 2 (, Mary atory arrest	Approximintarval B Onset and minut days years 24b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION DF (OF DEATH? 1 YES 2 1		
ED BY PHYSICIAN: MEDICAL	23. PART I. Enter the disease ahock, or heart fall immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death) LAST 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	a, or complications that cause inure. List only one cause on a. Septicem. DUE TO (OR AS DUE TO (OR	aach line. ia s a consequence of) on Pneumon s a consequence of); clerotic C s a consequence of); but not resulting in utpetient 3 □ DOA (1) Y 28b. Time INJU	Donal 313 T of entar the model in the underlying the underlying the underlying the underlying the underlying the underlying the underlying the underlying	dson Fur albott A de of dying, suc ascular g cause given in ACE OF DEATH (C) 5 - Residence URY AT RKY (ES 2 - NO	Dise	Laurel liac or reapiri 24a. WAS AN A PERFORM 1 YES 2 (p) (Specify) CRIBE HOW IN.	AUTOPSY MED? [X NO	Approximintarval B Onset and minut days years 24b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION DF (OF DEATH? 1 YES 2 1		
MPLETED BY PHYSICIAN: MEDICAL	23. PART I. Enter the diseases ahock, or heart fall immediate cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of the conditions of t	a, or complications that cause inure. List only one cause on a. Septicem. DUE TO (OR AS DUE TO (OR	asch line. ia s a consequence of: on Pneumon s a consequence of: clerotic C s a consequence of: but not resulting in utpatient 3 DOA y 28b. TIME INJU RY — At home, farm, stroectly)	Donal 313 T ot entar the model alia : Cerebrov : the underlying the underlying Test, pl OTHER: 4 Nursing Hom OF 28c. INJ. In Nursing Hom OF 28c. INJ. In Nursing Hom I	dson Fur albott A de of dying, suc ascular acause given in Ace of DEATH (C) e 5 - Residence URY AT (ES 2 - NO and place, and due	Dised Part I. Part I. 28d. DES 28f. LOCK City of	Laurel liac or reaping ase 24a. WAS AN A PERFORM 1 YES 2 (Specify) CRIBE HOW IN. ATION (Street and or Town, State)	MATY attory arrest MUTOPSY MED? X NO JURY OCCUR There is stated.	Approximinterval B Onset and minut days years 24b. WERE AUTOPSY FI AMPLIABLE PRIOR COMPLETION DE OF DEATH? 1 YES 2 1		
LETED BY PHYSICIAN: MEDICAL	23. PART I. Enter the diseases ahock, or heart fall immediate cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of the conditions of t	a, or complications that cause incre. List only one cause on a. Septicem. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (Month, Day, Year, (Month, Day, Year, (Month, Day, Year, Month). 28e. PLACE OF INJUR (Month, Day, Year, Month). 28e. PLACE OF INJUR (Month, Day, Year, Month). 28e. PLACE OF INJUR (Month, Day, Year, Month). 28e. PLACE OF INJUR (Month, Day, Year, Month). 28e. PLACE OF INJUR (Month).	asch line. ia s a consequence of: on Pneumon s a consequence of: clerotic C s a consequence of: but not resulting in utpatient 3 DOA y 28b. TIME INJU RY — At home, farm, stroectly)	Donal 313 T ot entar the model alia : Cerebrov : the underlying the underlying Test, pl OTHER: 4 Nursing Hom OF 28c. NJ RY WO 1 V	dson Fur albott A de of dying, suc ascular acause given in Ace of DEATH (C) e 5 - Residence URY AT (ES 2 - NO and place, and due	Disease Part I. Part I. 28d. Des	Laurel liac or reaping as a second of the s	AUTOPSY MED? (X NO	Approximinterval B Onset and minut days years 24b. WERE AUTOPSY FI AMPLIABLE PRIOR COMPLETION DE OF DEATH? 1 YES 2 1		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurial-transit nermit Panes 1 2 schould
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

		-					C	5	3525
	1 - STATE REGISTRAR	OF MARYLANI		TMENT OF I			GIENE		
	1. DECEDENT'S NAME (First, Middle, Last) AKA	RUTH J. GA	TES		DEATH	2. DATE OF D	EATH DAY	YEAR	3. TIME OF DEATH
	JERLINE RUTH 4. SOCIAL SECURITY NUMBER 5. SEX	GATES	s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH "	1995	PLACE (State or Foreign
	214-36-0551 1 D M 2	⋈ F 57	YRS.	BYAG SHTNOM	HOURS MIN.	October	6, 37	Country	yland
OR	9a. FACILITY NAME (If not Institution, give street end nur Frederick Memorial Hos				or Location of D derick	EATH		rederic	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Many land Frederick	- l.		Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?
	Maryland Frederi	CK	F	rederic	f. ZIP CODE		10a.		1XXYES 2 NO
FUNERAL	1000 Heather Ridge Dri				21701				States
B≼	11. MARITAL STATUS 1 X Never Married 2 Merried 3 Widowed 4 Divorced	ECEDENT EVER IN U.S ES? 1 TYES 2 GIVE WAR OR DATES	ARMED	If yes, sp	DECITION OF HISPA Decity Cuben, Mexico 5 2 NO Specific	in, Puerto Rican,		14. RACE Black Specifi	- American Indian, , white, etc.): White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		Give kind of u	USUAL OCCUPATE work done during me se retired.)	ON ost of working	16b. KIND	OF BUSINESS	/INDUSTRY	
MPL	12	0 1-4 or 5 +)	Di	etician			Food	Servi	ce
BE CO	17. FATHER'S NAME (First, Middle, Last) Mitchell O. Gates					Ruth Mai	~low		
2	190. INFORMANT'S NAME (Type/Print) Walter C. Lynch				and Number or Rural Naldorf,				
	20a METHOD OF DISPOSITION 1/2 / Burlal 2 Cremation 3 Removal from S 4 Donation/ 5 Other (Specify)	20b. PLA		of disposition (N	_{ame of} Gdns. Apr		20c. LOCATION		rf, Maryland
	MgB Mark G. Brohawn	M00053		THE	UNTT FUNE DX 156, V	RAL HO	ME, INC		
	23. PART I. Enter the diseases, or complication shock, or heart fellure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death)	one that coused the one cause on each The TRACION DUE TO (OR AS A COR	LANIA	L BLE		h as cerdiac o	r respiratory	arrest,	Approximate Interval Batween Onset and Death 34 445
CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A COM							
MEDICAL	PART II. Other significent conditions contributed by the significant con	Dulmon	ubopl	Ember	g cause given in	1_	WAS AN AUTOP PERFORMED? YES 2 NO		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPIT	28. P		H (Check only one)					
HYS		ent 2 ER/Outpetien	28b. TIM	4 - Nursing Hom	ne 5 🗆 Reeldence	8 Other (Spec		OCCUPED	
ВУ Р	1 Aletural 5 Pending 2 Accident Investigation	Month, Day, Year)	INJ	URY WO	YES 2 NO	EGG. BEGGINBE	. HOW MODEL	OCCORED	
ETED I	3 Suicide 8 Could not be 4 Homicide determined	PLACE OF INJURY — A pullding, atc. (Specify)	t home, farm, e	street, factory, offic	•	28f. LOCATION City or Town	(Street and Nun n, State)	nber or Rural Ro	oute Number,
OMPL	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the ba								and menner ee stated.
BE C	290. SIGNATURE AND TITLE OF CERTIFIER	40			29c. LICENSE NUI	MBER	29d. I	DATE SIGNED	(Monjh, Day, Year)
10	Milio Shapiro	SIY TO	(ITEM 27) (Type,	Print)	, Fned	wide	. Md	7.1	701
	31. DATE FILED (MORITI, Day, Year) 32. RE APR 2 0 1995 4	LA DANGLEN	Rardall	7,,,,	7	,			



		1 - STATE REGISTRAR		STATE OF M	IAKYL	AND / DEP CERT							YGIENI G. NO.	E			
		1. DECEDENT'S NAME (Firs	t, Middle, Last)	7.1)		7.11		D E A I		2. DATE OF D	EATH			3. TIME OF DE	ATH
	1	6 sels	0	Harr	11	5	~					April	1 1	199	YEAR	1:00	Ам
	-	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (in yr. last birtho		F UNDER 1 Y	\rightarrow	IF UNDER	24 HRS.	7. DATE OF BI	RTH		8. BIRTHPI	LACE (State or	
_		222-16-319	Š	1 □ M 2 💢 F	73	YR	s. Mo	ONTHS D	AYS	HOURS	MIN.	7-4-1	921		DE.		
should		9a. FACILITY NAME (If not is	nstitution, give i	street and number)			98	b. CITY, TO	WN OF	LOCATIO	ON OF DE	ATH		9c. COUN	TY OF DEA	ATH	
2, 3	DIRECTOR	Salisbury Nu	rsing	& Rehab	Cent	er	er Salisbury, Md.							Wicor	nico		
₩.		RESIDENCE OF DE	10b. COUNT	v		10c. CITY, TOWN OR LOCATION						Las word and					
Pa0e	E I	Md.	Wico							UN						10d. INSIDE CIT	
permit. Pages	FUNERAL (10e. STREET AND NUMBER		mico	_	Salisbury 101. ZIP CODE 109. CITIZEN OF								YES 2			
ışı		Rt. 50 & C	ivic A							2180					ISA	AI COOKTAIT	
21215-0020 al or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 X Dive		12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W	YES	2 NO If yes, specify Cuben, Maxican, Puarto Rican, etc.) Black, Whita, atc								White, atc.	dlan,		
215 atten se as	8	15. DEC	CEDENT'S EDU	CATION		18a. DECEDEN	T'S USI	UAL OCCU	PATIO	V	_	186. KIND	OF BUS	INESS/INDL			
21 al or for u	COMPLETED	Elementary/Secondary (College (1-4 or 5+)	Homen	T use re	etired.)	ng masi	r or working	g	II.e.					
AND the host detache	M	17. FATHER'S NAME (First, A	Aiddle Last)			пошеп	lake	S.L	Т	in MOTH	IED'S MAI	HOI ME (First, Middle,		D			
YL/	BE C	Clarence J						_	Massey			on					
MARYL retained by t 5 should be notified at		19a. INFORMANT'S NAME (Type/Print)			19b. MAIL	ING AD	DRESS (S	reet an			Route Number, Cl					
E, N y be ret sage 5 :	٩	Vernon W.		, Sr.						aline	e Dr	. Hebro	on,	Md. 2	1830		
ALTIMORE, death. Page 6 may be funeral director, page	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelon, crematory or other place)										ATION — C		n, Stata				
Page al dire		4 Donation 5 Other (Specify) Laurel Hill Cemetery 4-14 Laurel, De.										De.					
0 =		willion	70	0 V	V. St	t. L	l Home; aurel,	De.	1995	6							
in 24 hours ely filled in nation, or n		23. PART I. Enter the dehock, or he immediate CAUSE (Find disease or condition resulting in deeth)	eert fallure.	a. The analysis one cause	se on e	ech line.	Cal	enter the		1		n es cerdiac i		atory arre	at,	Approxir intervel Onset ar	Between
N B 5 - 61	_		-	, /0	(OH AS A	CONSEQUENC	E OF):										
OX 68 e be execute sician and control to buria traumatic	CERTIFICATION	Sequentially list condit if any, leading to imme	COMBEDUENC	OF):	760								July				
BO ficate b physicia ne prion	CA	ceuse. Enter UNDERLY CAUSE (Disease or Inju	A COMPEQUIPMENT OF														
	Ë	thet initiated evente DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST															
DS, P.O. the death certi the attending d Mental Hygie	8		-	đ	_											-	
ORDS, I s that the death ned by the atte lith and Mental any injury.		PART II. Other significa	ant condition	e contributing to	deeth bu	ut not resultin	ng in t	the unde	lying	ceuse g	iven in i	Part I. 24a.	WAS AN A			VERE AUTOPSY	
S that hed by lith and	DICAL												YES 2		0	WAILABLE PRIOR COMPLETION OF OF DEATH?	
w requires that been signed pt. of Health a shows any	MED											_ /				YES 2	NO
AL REC law requires as been sign Dept. of Heal 23 shows	ÿ	DID TOBACCO U		RIBUTE TO CAI	USE O	F DEATH	YES			UNC	ERTAIN	1 🛛					
at at the	S	25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:		26. PLACE OF D		Check only	one)								
CIAN:	PHYSICIAN:	1 TYES 2 NO		1 Inpatient 2 I			4 4 4	Nursing	Home	5 🗆 Red	aldanca	8 🗆 Other (Spe	cify)				
ON OF VI DING PHYSICIAN: After this certifica death with the St marked, or it	ВУ РН	27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation	28a. DATE OF (Month, Da		286.	TIME OI INJURY	Υ	WOR YE		NO	28d. DEŞCRIBI	E HOW IN	JURY OCC	JRED		
SIC TENDI OR: A fter d	8	2 Culatela	Could not be datermined	28s. PLACE OF building, a	TINJURY	— At home, far	m, atree	ef, factory,	offica			281. LOCATION City or Tow		nd Number o	or Aunel Aou	ite Number,	
DIVI OR AT DIRECT hours a	PLET	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of	my knowl	edge, daath occ	urred a	it the time.	data a	ind place,	and dua	to the cause(a)	and manr	ner as state	d.		
HOSPITAL FUNERAL within 72 I	COMP	one) 2 MED	ICAL EXAMINE	R: On the beals of ax												end mennar as	atated.
TO THE HOSPI TO THE FUNER be filed within	BE	29b. SIGNATURE AND 13714	OE CERTIPLE							29c. LICE	NSE NUM	SU9		29d. DATE	SIGNED (A	Month, Day, Year	2
	2	30. NAME AND ADDRESS O	F PERSON WH								1	1-1		7	1	13,	
		WILLTAM ROF 31. DATE FILED (Month, Day,		1.D., 1104 32, REGISTRA	HEA B'S SIGN	LTHWAY	DR	S	ali	sbur	V. N	id.					
3		APR 1	,	Jalin da	udlar	Redall											
				1/						_							

and and de profession

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach to filed within 72 hours after death with the State Devi. of Health and Mental Hydiene prior to burial, cremarion, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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PITAL	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be fled within 72 hours after death with the State Deut of Health and Mental Hydiene prior to burlal, cremation, or removal	T. II
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APR 17 1995

32. REGISTRAP'S SIGNATURE

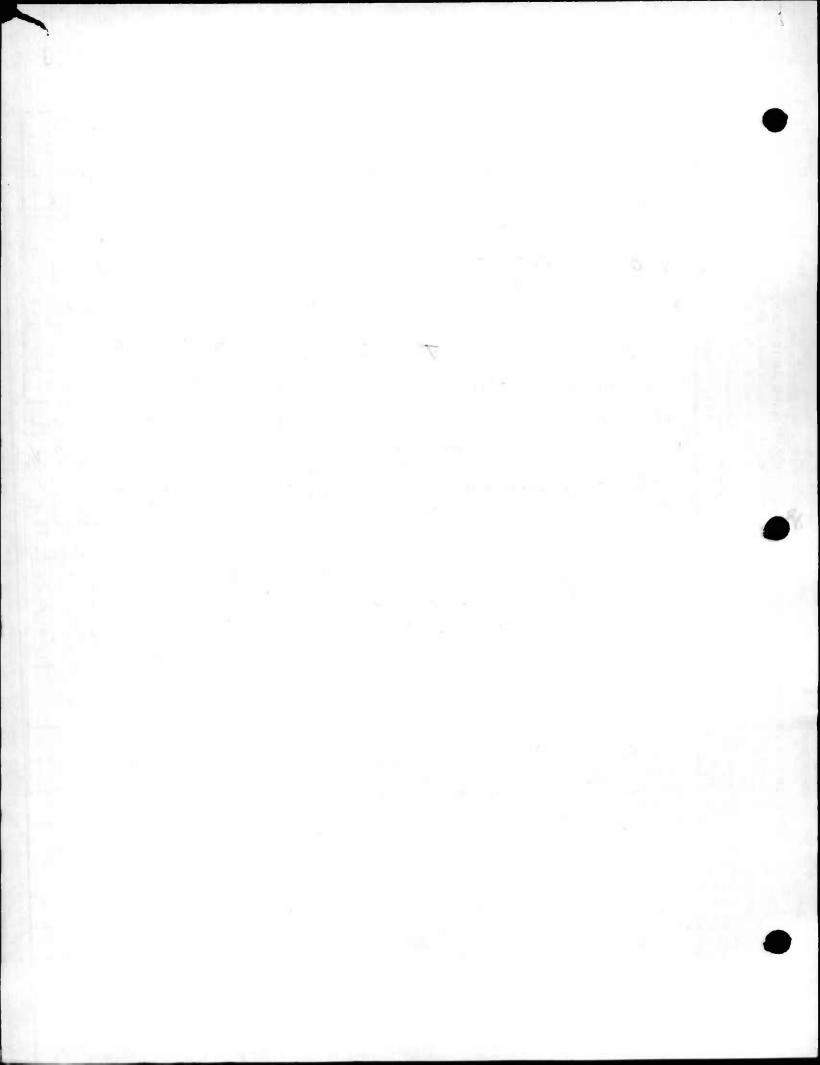
	FOR	0747- 0F N												
	1 - STATE REGISTRAR	STATE OF N	IARYLAND / Ce		ICATE					IYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF			YEAR	3. TIME OF DEATH	1
	Irving		Holbr						4		12	95	2115	M
	4. SOCIAL SECURITY NUMBER 222-03-8120	5. SEX	6. AGE (In yrs. les		IF UNDER 1 Y	EAR IF U	NDER 24 H	RS. 7	7. DATE OF (Month, D	BIRTN py, Year)	_	8. BIRTH Countr	IPLACE (State or Fore	vign
		1 🐼 M 2 🗆 F	77	YRS.						6-1	7		ginia	
~	90. FACILITY NAME (If not institution, give at 608B South Wes		mirro		96. CITY, TO				TH	EATN				
5	RESIDENCE OF DECEDENT	cover D	er Drive Salisbury Wicon										100	
DIRECTOR	10a. STATE 10b. COUNTY	1		10c, CIT	TY, TOWN OR I	OCATION							10d. INSIDE CITY	
P	Maryland Wicon	nico		5	alisl	nirv							LIMITS?	ю
AL	10e. STREET AND NUMBER					101. ZIP	CODE				10g. CI	TIZEN OF V	WHAT COUNTRY?	
ER	608 B S.Weston	ver Driv	ve				2180	01			U	.S.A		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT		MED	13, WA	DECENDE	NT OF N	SPANIC	ORIGIN? (S	pecify Yes			E — American Indian k, White, etc.	١,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			YES 2			ruento mice	n, etc.)		Speci		
	15. DECEDENT'S EDUC	WW:		CEDENTIA	USUAL OCCL						10.2020		DIACK	
ETE	(Specify only highest grade	completed)	(G	ive kind of Do NOT u	work done duri we retired.)	ng most of w	vorking		16b. Kil	NO OF BU	SINESS/IN	DUSTRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5 +	,	Labo						Non	0			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				TCL	18. 0	MOTHER'S	S NAME	E (First, Midd		_			
BE C	Charles Holbro	ok:				- 1			Hit					
10 B	19e INFORMANT'S NAME (ImpoRpint)										ip Code)		.:-	
۲	Lucille Robins	son	60	08 B	. Sout	h We	esto	ove	r Dr	. Sa	lisl	burv	,Md.218	01
	20e, METHOD OF DISPOSITION 1) Burial 2 Cremation 3 Remo	oval from State		AND DATE	OF DISPOSITIO			0.0	DATE			- City or To		
	4 Donation 5 Other (Specify)				11 Ga	ırde	as		4/17	Н	ebro	on M	d.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CA ON THE TRANSPORT OF THE PROPERTY OF THE PROPER													
	Gladys B	Stere	art						raı Sali			44 2	1001	
	23. PART I. Enter the diseases, or o	omplications that	coused the de	eth. Do	not enter the	mode of	dying,	such a	as cardiac	or respi	iratory a	rrest,	Approximat	a
	shock, or heart failure.	List only one ceu	se on each line).									Interval Bet Onset and	
- 1		Metas	tatic (Carc	inoma	ì							year	
- 1	resoluting in country	DUE TO	OR AS A CONSE	NSEOUENCE OF):									Jean	
Z	Sequentially list conditions,	D	noma Pi										year	S
CERTIFICATION	if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE O	F):									
5	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE 70	(OR 48 4 00)											
E	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEC	QUENCE O	F):									
ij	Secretary Community	d												
A.	PART II. Other significant condition	s contributing to	death but not r	esuiting	in the under	lying ceu	se give	n in Pa	art i. 24	. WAS AN		24b.	WERE AUTOPSY FINI	
MEDICAL	Hyperthyroid,	Hyper	tension	1					_ 1	☐ YES 2			AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?	
ME	Arteriosclero	otic Car	rdiovas	scul	ar Di	seas	зе		_				1 YES 2 NO	0
ä														
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				6. PLACE (OF DEATH	V (Check	only one)					
YSI	1 No Septial: 1 No Septial: 1 Inpatient 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)													
F	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF (Month, Da	INJURY ly, Year)	26b. TIN	JURY	WORK?		- 1	8d. DEŞCRI	BE NOW I	NJURY OC	CURED		
B	2 Accident Investigation					YES	2 NC							
	3 Suicide 6 Could not be 4 Homicide determined	building,	F INJURY — At ho etc. (Specify)	me, farm,	street, factory,	office		2	Bf. LOCATIO	ON (Street e own, State)	and Numbe	or Plumal F	Route Number,	
	29e. CERTIFIER		C-115/102								_			
COMPLET	(Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE) and manner as star	ted.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	0 10	00 T	ת נ	ME		LICENSE 035		ER			4-13	(Month, Day, Year)	
2	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	E CE DEATH GT				,~,)	ノフフ				4-15	プラフラ	
- 4	John T. Bulkel	ev. M.T	108	- an inve	ne Rl	nff	Бď		Cali	chur	077	E M	21801	
H	0		, , , , , ,		TIC DI	итт	II U a		1 1 15 6	0 11111	· V -	IVI () .	7 18111	

Land Congression

filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ion, or removal. urs after death. Page 6 may be retained by the hospital or attending physician. signed by the attending physician and completely filler Health and Mental Hygiene prior to burial, cremation, HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremat this certificate has been with the State Dept. of I 23 Item 70 marked, 28 is TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2

> 8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF BEATH E. L ALVIN 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Fo 1 X M 2 - F Year) YRS 10-90. FACILITY NAME (# 9c. COUNTY OF DEATH 9 Md DIRECTOR reld rerset RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY md Worces OCOMORE YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1006 2185 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married If yes, specify Cube BY 3 Widowed Specify 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of life. Do NOT use retired.). 15. DECEDENT'S EDUCATION (Specify only highe 16b. KIND OF BUSINESS/INDUSTRY Asplundah Co Elementary/Secondary (0-12) 6 Trimmer 17. FATNER'S NAME (First, Middle, Last)
WIN Pred 18. MOTHER'S NAME (First, Middle, Maiden H.11 WIN be notified at BE us 19a, INFORMANT'S NAME (Type/Print 2 Walker 11/0.1 Va 23336 METHOD OF DISPOSITION must 20b. PLACE AND DATE OF DISPOSITION /A OATE 20c. LOCATION Burial 2 Cremation 3 🗆 R Donelion 5 - Other (Specify) yor examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Fun el HOM Tone event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) da DUE JU OR AS A CONSEQUENCE OF traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING 00 Ruce CAUSE (Disease or injury that initiated events reaulting in death) LAST 0 Injury, PART II. Other aignificant conditions contributing to death but not resulting MEDICAL cause given in Part I. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDS shows any PERFORMED? WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? T YES 2 X NO 1 □ VEB 2 PENO PHYSICIAN: um 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL:
1 M Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED 1 X Natural 5 Pending м BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, tectory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 🛣 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axa-296. SIGNAPONE AND TITLE OF CERTIFIE BE 29d. DATE SIGNED (Month, Day, Year) 29505 4-13-95 1000 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GORIO M. BELLOSO, M.D. 4421 BEECHWOOD PL. CRISFIELD, MD 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE



BY PHYSICIAN: MEDICAL CERTIFICATION

COMPLETED

BE

2

CAUSE (Disease or injury thet initieted events resulting in death) LAST

1 TES 2/ NO

5 Pending

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED/(Month, Day, Year)
APR 1 8

8 Could not be datarmined

27. MANNER OF DEATH

Natural

2 Accident

3 Suicide

4 Homicide

TO BE COMPLETED BY FUNERAL DIRECTOR

						95	13529
	1 - FOR STATE OF MAR	RYLAND / DEPAR CERTIFI	TMENT OF I		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)			3	2. DATE OF DEATH		3. TIME OF DEATH
ĺ	DARA B. Hancock				1 1 1	G 95	1050 M
		GE (In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	J. DATE OF BIRTH		HPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and number)		96. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH
ı	PENINSULA REGIONAL MEDICAL	CENTER	SALIS	SBURY		WICO	OMICO
	RESIDENCE OF DECEDENT						
	Virginia 10b. Spunty		inco tea				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	6195 Ocean Blvd.		10	23336		10g. CITIZEN OF	WHAT COUNTRY?
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EV. FORCES? 1 NEVER STATES IF YES, GIVE WAR OF YES.	YES 2 NO	If yes, s	CENDENT OF HISPAI Decify Cuben, Mexica 3 2 NO Specif	NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.)	Bia	CE — American Indien, ck, White, etc.
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Ille. Do NOT use	vork done during m	ON ost of working	166. KIND OF BU	SINESS/INOUSTRY	
	17. FATHER'S NAME GIST, MIDDIO, LOSD, John Henry Marshall	in		18. MOTHER'S NA	AME (First, Middle, Meiden	Surneme)	
	180. INFORMANT'S NAME (Type/Print) Mary Clark	19h MAJLING 6224 0	cean Bl	and Number of Ryral va. (nin	Route Number, City or Tow Coteague,	Virginia	23336
	20e_METHOD OF DISPOSITION 1	206. PLACE AND DATEO	PEDISPOSITION IN	arme of	OATE 200 LO	cation - city or 1	Town, State.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gonstavee SG. B.	zilesy	22. Name (nco teagu	ruit Home e, Virginia	a 23336	
	PART I. Enter the diseases, or complications that cat ahock, or haert feliure. Liet only one cause of IMMEDIATE CAUSE (Fine)	used the deeth. Do no in each line.	ot enter the mo	da of dying, auc	ch as cardiac or respi	ratory arrest,	Approximate interval Between Onset and Dasth
	disease or condition a. Card	AS A CONSEQUENCE OF	7:				min
	Sequentially list conditions, b. Cefree	Torn hear !	fail	ul			grs
	if any, leeding to immediate couse. Enter United CAUSE (Disease or injury)	roschiote.	2 2 1	it dise	ese		ins

24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 - 10 Phrence DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

PART II. Other eignificent conditions contributing to death but not recuiting in the underlying cause given in Part i.

26. PLACE OF OEATH (Check only one) OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specily) 1 Inpatient 2 ER/Outpetient 3 DOA

28c. INJURY AT WORK?

1 YES 2 NO

28b. TIME OF INJURY

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

28d. DESCRIBE HOW INJURY OCCURED

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO

24b. WERE AUTOPSY FINDINGS

29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)

2 MEDICAL EXAMINER: On stion end/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(e) and manner as stated.

ast

28e. OATE OF INJURY (Month, Day, Year)

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) POBIX 2636 Salisbury

32. MEGISTRAR'S SIGNATURE

29c. LICENSE NUMBER D1928

29d. OATE SIGNED (Month, Day, Year) 116/95

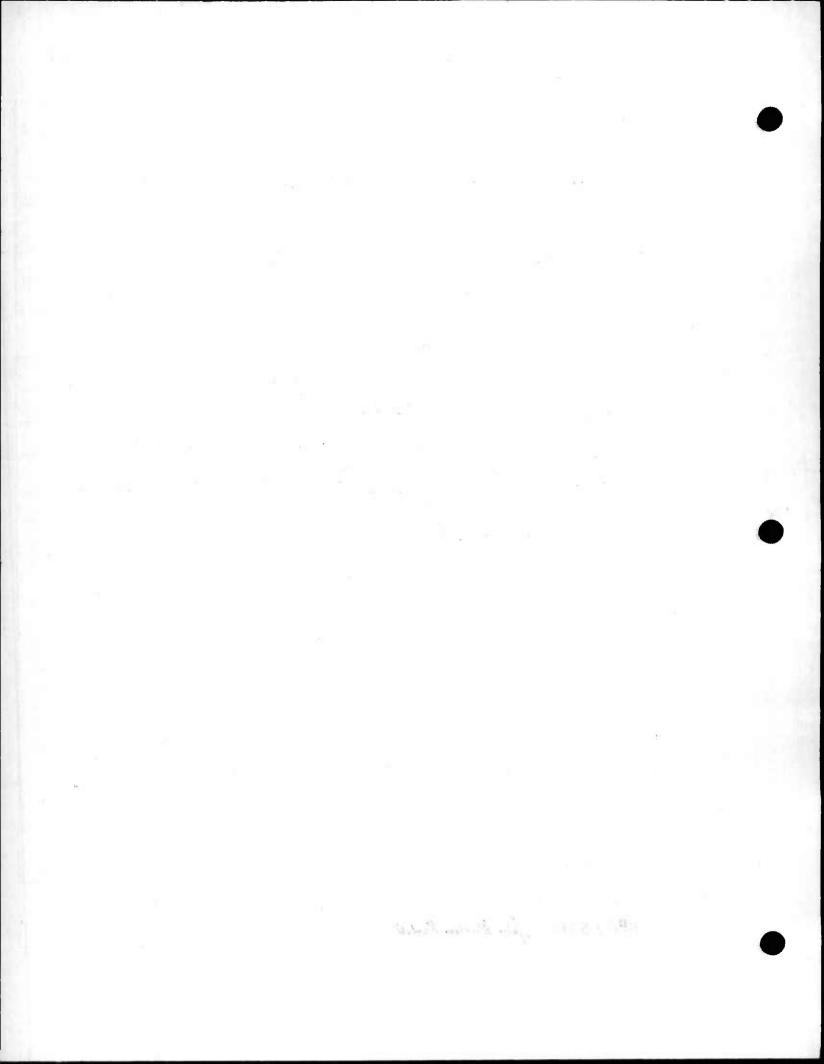
alimate of North pro-

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

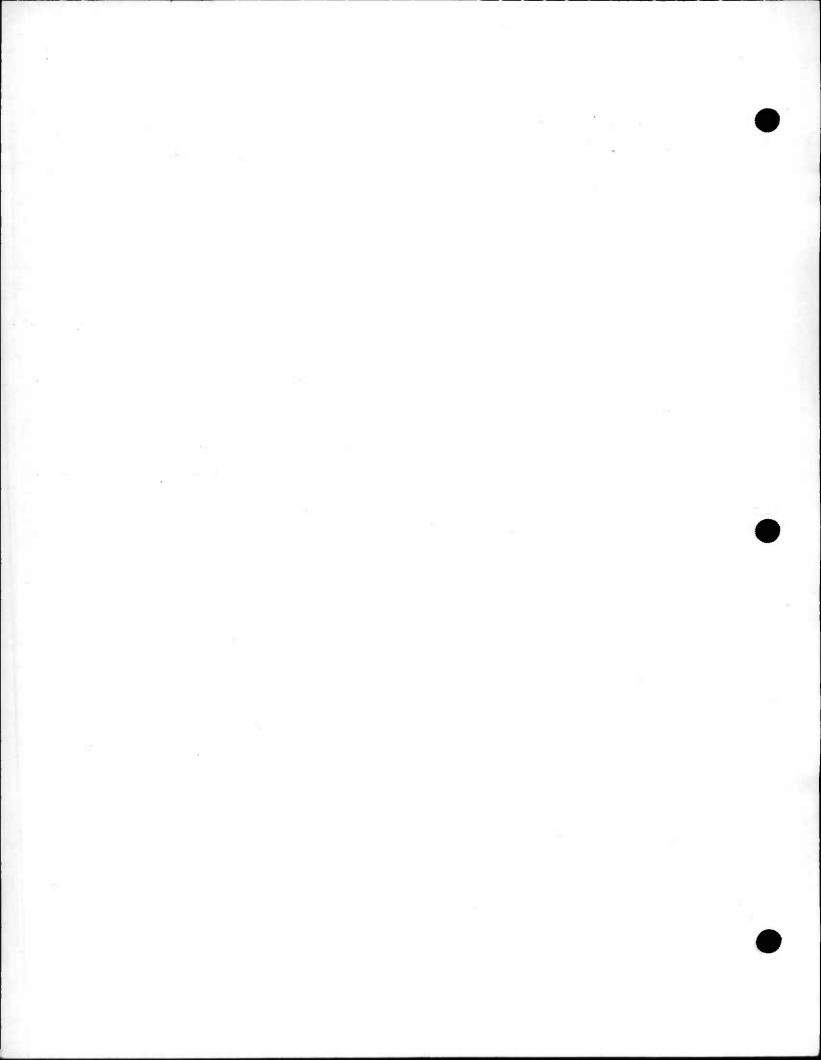
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cardicals be encouned within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician may compete the burning of the property of the property of Health and Mental Hypers price to burning committee, and the property of the physical property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the propert	THE CHIEF I WIND TO SEE THE PROPERTY OF SECURITY OF SE	THE PARTY OF THE P
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	1 - FOR STATE REGISTRAR	STATE OF A		D / DEPAR Certif					ITAL HYGIE REG. N	NE	, ;	3330
	1. DECEDENT'S NAME (First, Middle, Lest) JAMES	James V	irgil	Hanco	ck Si	. н	ANCOC	'K '		DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 214-36-5248	5. SEX	6. AGE (In yr.	s. last birthday) YRS.	IF UNDE	1 YEAR	IF UNDER 24	HRS. 7. I	PRIL DATE OF BIRTH (Month, Day, Year) Oril 22, 19	15	Countr	7:55A M PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CIT	, TOWN	OR LOCATION)[][22, 1:		UNTY OF D	
DIRECTOR	60 FOOT ROAD	AND US	50		P	ITT	SVILL	E		ICO		
3	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION			***		10d. INSIDE CITY
		comico			Sali	sbu	У					LIMITS?
FUNERAL	32986 Johnson	Rd.	Rd. 101. ZIP CODE 10g. CITIZEN OF 1 USA USA							HAT COUNTRY?		
5	11. MARITAL STATUS	12. WAS DECEDEN			13.	WAS DEC	ENDENT OF I	VISPANIC O	RIGIN? (Specify Y	es or No-	14. RACE	- American Indian,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W					ecify Cuban, I 2 ⊠NO		erto Rican, etc.)		Special Whi	
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a	DECEDENT'S	USUAL O	CCUPATIO	ON st of working		16b. KIND OF B	USINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 -		(Give kind of life. Do NOT u				er	Truck	ing/I	Poult	rv
S S	8 Truck Driver/Poultry Grower Trucking/ 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Sumann											- 7
BEC	Ralph	Hanco	ck					ssie			Perdu	e
6	19a. INFORMANT'S NAME (Type/Print)			196. MAJLING	ADDRES	S (Street a	nd Number or	Rural Route	Number, City or To	wn, State, Z	(ip Code)	-
-	Mary K. Hancock			3298	36 Jo	hns	on Rd.	, Sal	lisbury	MD	21801	
	20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of Town											
	Cameton 3 Ramoval from State Cameton 3 Ramoval from State Cameton, cramatory or other place) Cameton, Cameto											
	Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD											
	11.1	tellou	rav			501	Snow	Hill	Rd., Sa	lisbu	ury,	MD 21801
NOI	Anock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition a. MULTIPUT MUCICI DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions.											Approximate Intervel Between Onset and Death
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PHYSICIAN: MEDICAL	PART II. Other significent condition	s contributing to	death but n	ot resulting	resulting in the underlying cause given in Part I.					N AUTOPSY PRMED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
÷	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF D	EATH YE	SΠI	VO [UNCER	TAIN [ı İ			1 TES 2 NO
Ŋ.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			LACE OF DEA			011021		-			
S	YES 2 NO	HOSPITAL:	ER/Outpetien	t 3 🗆 DOA	OTHER		5 - Reside	ence &/GV	Other (Specify)	ROZ	N.D.	
됩	27. MANNER OF DEATN	26a. DATE OF (Month, De	INJURY	28b. TIM	E OF	28c. INJ WO	JRY AT		DESCRIBE NOW	INJURY OC	CCURED	BYVEHICLE
BY	1 Natural 5 Pending 2 Accident Investigation	4 15	95	072	M 40.	1 🗆 1	ES 2 N	0 00	LIVER OF	PICK	UPTRU	cal smuar
	3 Suicide 6 Could not be	28a. PLACE Of building,	etc. (Specify)	t home, farm,	street, feci	ory, office		261.	LOCATION (Street City or Town, State	and Numbe		
		RO	QA					60			50 4	100 MILLOCO MS
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2X MEDICAL EXAMINED	CIAN: To the best of R: On the bests of ax	my knowledge amination and	, death occurr	ed at the t	me, data pinion, d	and place, an	d due to the	e cause(s) and m	nner ea ste	ated. the cause(a)	and manner ea stated.
	290 SIGNATURE AND TITUE OF CERTIFIER						29c. LICENS					(Month, Day, Yeer)
O BE	Maybre Breyk	ryll	O.C.M.E.							► APRIL 16/95		
2	39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YAMYDAGO A. LOREW MA 111 PENN STREET BALTIMORE MARYLAND 21201											
	APR 1 8 1995	32 AEGISTHA	R'S SIGNATUR	arlall								



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	F HEALTH AND OF DEATH	MENTAI	HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF OEATH		YEAR 3. T	IME OF DEATH	_
	Ì	***************************************	elle		Hen	se	Apri		1995		6:30	M
		4. SOCIAL SECURITY NUMBER		in yrs. lest birthday)	IF UNDER 1 YE			OF BIRTH , Day, Year)			E (State or Foreign	
밁		213 46 5613	1□M212F 94	YRS.				30, 1		MD		
. 2, 3 should	DIRECTOR	98. FACILITY NAME (If not institution, give st Calvert Memorial RESIDENCE OF DECEDENT				vn on Location of Frederic				y of DEATH 1vert		
permit. Pages 1.	EC	10e. STATE 10b. COUNTY	The state of the s	10c. CIT	Y, TOWN OR LO	OCATION				10d.	INSIDE CITY	
±. 2.	ā	MD Cal	vert	H	Nunting	town				1 🗆	LIMITS?	
E B	FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?	
an. ransit	Ä	5851 Mill Branch				20639			USA			
MARYLAND 21215-0020 interind by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	It yes	DECENDENT OF HISP , specify Cuban, Mexi YES 2 1 NO Spec	can, Puarto F	or No- 1	merican Indian, ite, etc. White			
1215 rattend use as	8	16. DECEDENT'S EDUC (Noncity only highest grade :	ATION	18e. DECEDENT'S	USUAL OCCUP	PATION	16b.	KINO OF BUS	SINESS/INDU	STRY	WIIICE	_
12 g g 2	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done during se retired.)	most of working						
AND 21 the hospital or detached for u	MP	12	12.83	clerk			'	U.S. G	overni	ment		
YLAN by the ho be detact at energy		Arthur Fulton	Middleton			18. MOTHER'S N						
IARYI tained by should be tiffied at	98	19s. INFORMANT'S NAME (Type/Print)	HIGGLECOU	1		Susanr						
RE, MARY ay be retained to page 5 should be notified	٥	Robert A. Hense same as 10 above										
F 6 may rector, pag		20b. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery, cremetery or other place) St. John's Epis. Cem. 20c. LOCATION - City or Total Cemetery, cremetery or other place) St. John's Epis. Cem.										
IMOR Page 6 m i director, ver must	- 1	21. SIGNATURE OF UNERAL SERVICE LICE		John's		E AND ADDRESS OF I		Reli	tsvill	.e, M	D	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		· M. Mus	al Pho	0	Raus	ch Funera	al Hom				D 20736	ŝ
760 Ed within 24 hours ompletely filled in it, cremation, or re-	Z	IMMEDIATE CAUSE (Finel disease pr condition resulting in death)	list only one cause on e	och line.		moda of dying, su				nt,	Approximata Interval Batwe Onset and Dec 3	
P.O. BOX the certificate be es anding physician a Hygiene prior to or other traum	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O								
L RECORDS, F law requires that the death lax been signed by the atten bet. of Health and Mental 23 shows any injury.	MEDICAL	SIP P. E	merlia.				_	24a. WAS AN PERFOR 1 YES 2	MED?	AVAIL COM OF D	E AUTOPSY FINDING ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO	
	PHYSICIAN:	DID TOBACCO USE CONTR					IN 🗆					
ate at	S	EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:							
certification the Street	¥ l	1 YES 2 NO	1 Inpatient 2 ER/Output 28e. OATE OF INJURY	28b. TIM		iome 5 - Residence	_					
NG PHYS frer this eath with	- 40	Natural 5 Pending	(Month, Day, Year)	th.j	URY	tNJURY AT WORK? YES 2 NO	28d. DEŞ	CRIBE HOW II	AJURY OCCU	RED		
WDING R WDING R WDING R WDING R	BY	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF INJURY	— At home, farm,			28t LOCA	TION (Street a	nd Number or	Rumi Bauta I	Meronhor	_
ATTER ATTER S after	ETEC	4 Homicide determined	building, atc. (Speci	f(y)			City o	r Town, State)	no Number of	PIDIEI PIDUIS I	vurrioer,	
로 국 전 등	COMPLETED		: On the best of my knowle								manner sa stated.	
THE HO THE FU filled wit	шШ	296. SIGNATURE AND TITLE OF CERTIFIER	00 0 000	. 6	>Λ	29c. LICENSE NU	JMBER		29d. DATE S	IIGNED (Mont	h, Day, Yeer)	_
TO THE HOSPIT TO THE FUNERA DE filed within 7	w	HI Melvol.	M. Alle	rding 1	Kyn'c	D 194	127		▶ 4	18	195	
1	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print		/			+ -		_
10			ce Frederick		678							
		31. DATE FILED (Month, Day, Year) APR 9.1 1995	32. REGISTRAR'S SIGNA	•								
	- 6	APR 7 1 1447	THUR WHUNDING	MANAGE								

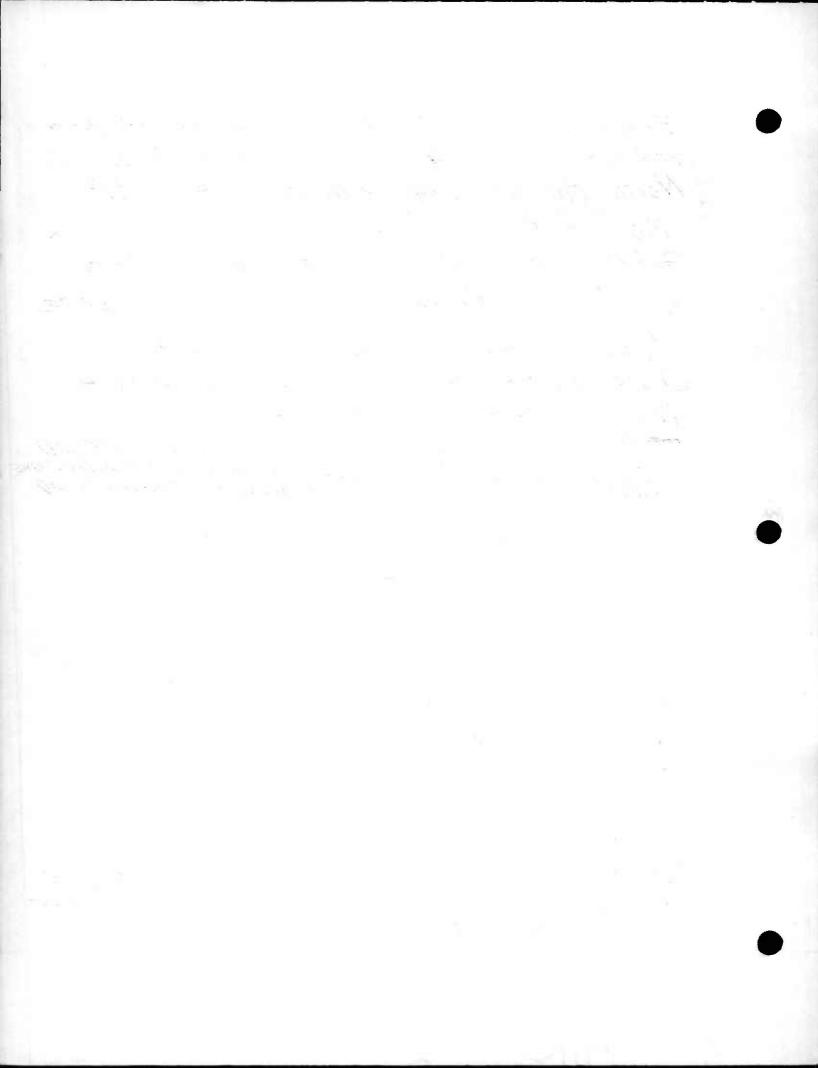


BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	_	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH WONTH DAY VEAB 13.76 13.76 13.76										
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR MONTHS DAYS HOURS MIN. MONTHS DAYS HOURS MIN. MONTHS DAYS HOURS MIN.										
pino		98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH										
1, 2, 3 should	RECTOR	North Arundel Hosp Glen Burnie AA.										
<u>~</u> ;	DIREC	106. STATE 106. COUNTY A. A. 10c. CITY, TOWN OR LOCATION Securize DATK 10d. INSIDE CITY LIMITS? 1 Uses 2 Umo										
burial-transit permit.	UNERAL	100. STREET AND NUMBER 2 SPring haven Court 21146 USA										
the burial-tra	BY FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Never Married 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yaa or No— If yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. RACE — American Indien, Black, Whita, alc. 1 YES 2 No Specify: Specify:										
e as	E	15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working										
اِ اِ	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) S X S Terms Analyst NSA										
8 76	- 4	17. FATHER'S NAME (First, Middle, Last) Charles Wallock Hook (Charles WAPLE)										
o should	O BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
		PATIVIC (A 1700 C SAME AS #10 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of) DATE 20c. LOCATION - City or Town, State										
		2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY										
e runeral II. examin	!	22. NAME AND ADDRESS OF FACILITY AND SONS FENERALISM HAS PLTZING HOW SONS FENERALISM HAS PLTZING HOW SONS FENERALISM										
or removal.		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between										
tion,		IMMEDIATE CAUSE (Finel disease pr condition resulting in death) s. Ventricular Fibrillation Due TO (OR AS A CONSEQUENCE OF):										
urial,	DUE TO (OR AS A CONSEQUENCE OF):											
	CALIC	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING										
e e	HIFIC	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):										
	E E	d										
iniu	EDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO										
Hear W	E C	t U YES 2 UND COMPLETION OF CAUSE OF DEATH?										
50 KM	N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO										
State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
d, or	PHY S	1 Ves 2 No 1 inpatient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 288. DATE OF INJURY 289. TIME DF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED										
mari	4	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO										
28 after		3 Suicida 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, lectory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, lectory, office City or Town, State)										
10 =	MPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, dasth occurred at the time, data and placa, and due to the ceuse(a) and manner ee attried.										
within 72 h	3	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and placa, end due to the cause(e) end manner se steted. 29b. SIGNATURE AND TITLE DF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dark Year)										
E 8 2		Whin & Anno Deputy D 06054 +4/24/95										
'		30, NAME AND ADDRESS OF PERSON WHO COMPYETED CAUSE OF DEATH (ITEM 27) (Typo, Hint) William P. Jowes, M.D., 695 America 21035										
		31. DATE FILEO (Month, Day, Sper) 2 7 1995 REGISTRAP'S SIGNATURE APR 27 1995										



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

5

										95	13533
1 - STATE REGISTRAR	STATE OF MARY					EALTH AND N	MENTAL	HYGIEN REG. NO.	IE		
1. DECEDENT'S NAME (First, Middle, Last))	-					2. OATE O	OF DEATH	2011	YEAR	3. TIME OF DEATH
	ES E. HICKS				-		APRIL		995	TEAH	8:15am м
4. SOCIAL SECURITY NUMBER	0-10-200	GE (In yrs. last birt	MOM	UNDER 1 YEA	EAR AYS	IF UNDER 24 HRS.	7. DATE 0 (Month,	DE BIRTH Day, Year)		8. BIRTH Count	HPLACE (State or Foreign
220-58-1403		49 Y	YRS. MON	ITHS UM	YS	HOURS MIN.		28 19	45 _	D.C	
9a. FACILITY NAME (If not institution, give 1121 EASTPORT TE				ANNA]		DR LOCATION OF DE	EATH			NE A	RUNDEL
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		1	IOc. CITY, TO	I SO TANK	COAT						The second second
MARYL A ND ANN	NE ARUNDEL			POLIS	S						10d. INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBER 1121 EASTPORT TE	ERRACE		_			21403			1	SA	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYPE IF YES, GIVE WAR OR	ES 2 NO	,	If yes	16, Spe	ENOENT OF HISPAN ecity Cuban, Maxicar 2 NO Specify.	n, Puerto Ri	(Specify Yealcan, atc.)	or No-		E — American Indien, ik, White, etc. ÄCK
15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 4th	ON st of working	16b.	KINO OF BUS	SINESS/IN	OUSTRY						
17. FATHER'S NAME (First, Middle, Last)	Surname)	-									
JOSEPH HICKS ANNIE SIMMS											
19a. INFORMANT'S NAME (Type/Print)		19b. M/	AILING AOC	ORESS (Str	reet er	nd Number or Rural R	Route Numbe	er, City or Tow	n, Stete, Zi	ip Code)	
ANNIE SIMMS		11	.21 E/	ASTPO	ORT	T TERRACE	E ANN	APOLI	S, M	D. 27	1403
20a. METHOD OF DISPOSITION 1 🂢 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)		20b. place and i ANNA POL		EM. C	GAR	RDENS 4/2		ANN	APOL	IS, N	
21. SIGNATURE OF FUNERAL SERVICE LI	Reese			821	WE	& SONS MEST ST. A	ANNAP	OLIS,	MD.		01
IMMEDIATE CAUSE (Finel	r complications that ceus b. List only one ceuse on	sed the deeth. 1 eech line.	. Do not e	enter tha	mod	ia of dying, such	h as cardi	ec or respi	ratory ar	rast,	Approximats Interval Between Onset and Death
disease or condition resulting in death)	e. DUE TO (OR	S CONSEQUEN	MCE OF	pul	1/1						4-17-95
Sequentielly liet conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST	c. Ulusu due to con as d. Alusto	S A CONSEQUENT S A CONSECUENT	oder	(use))						5/28/45
PART II. Other eignificent condition	ns contributing to death	1 but not resul	iting in th	ie underi	iying	ceuse given in f		24a. WAS AN PERFOR 1 YES 2	RMED?	24b	D. WERE AUTOPSY FINDINGS AYAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONT	TRIBUTE TO CAUSE	OF DEATH	YES	□ NO	X	UNCERTAIN			/ .		1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF			one)				2 1		
1 TYES 2 NO	1 Inpatient 2 ER/O	Julpatient 3 🗆 f	DOA 4	THER: Nursing I	Home	e 5 🗆 Realdence (6 Other	(Snecify) A	4 1	A-40	

28d. OESCRIBE HOW INJURY OCCURED 27. MANNER OF GEATH 28e. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT WORK? 1 Natural
2 Accident
3 Suicide 1 YES 2 🗌 NO 28a. PLACE OF INJURY — At home, tarm, straet, tactory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 __ MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mennar as stated.

214

296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
(1) (M. Marthe, Mart)	1000	11/20/00

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH HIEM 27) (Type, Print)

31. DATE FILED (Month, Day, M 32. REGISTRAR'S SIGNATURE Jalia Saudson Randall Year 2 1995

determined

DHMH-16 Rav 1/69

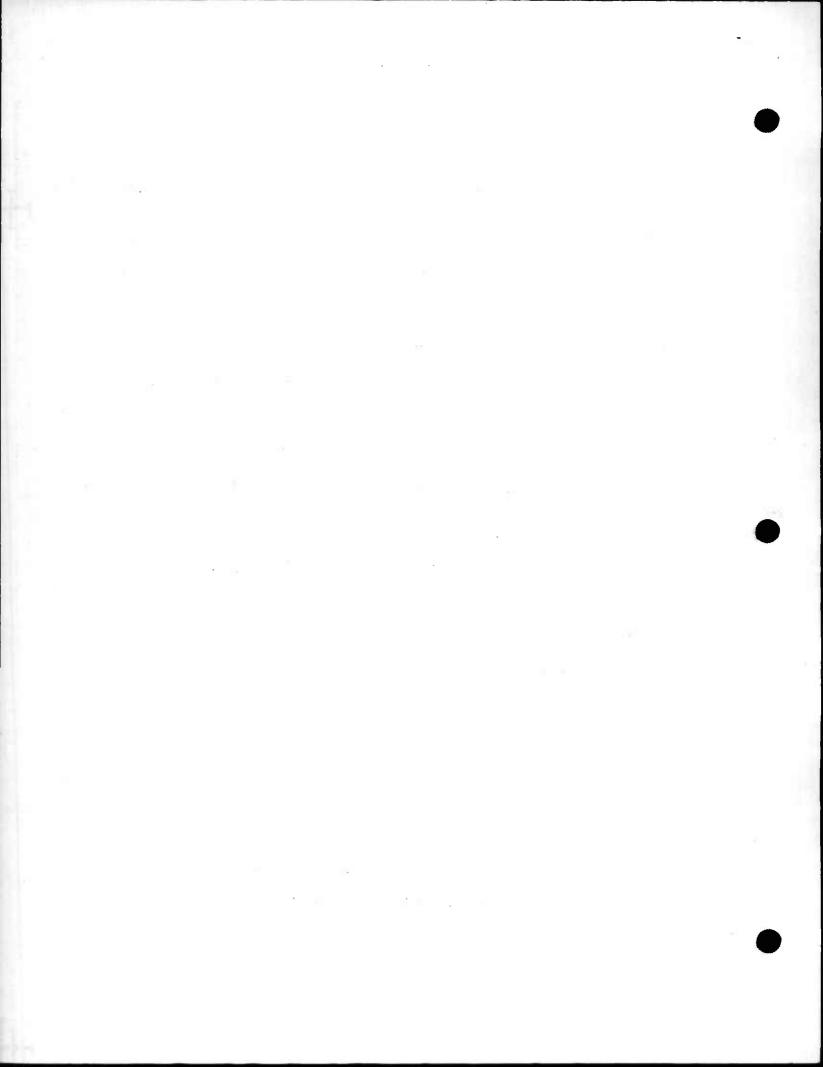
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		TIEGIOTTIAIT				OLI	THE ICA	AIL U	T DEA	111	Н	IEG. NO.			
		1. DECEDENT'S NAME (First	, Middle, Last) Lzabeth	ъ т.	ones		1	To a sam	_		2. DATE OF	DEATH	Y	YEAR	3. TIME OF DEATH
				1 0	ones	· · · · · · · · · · · · · · · · · · ·		Hearn	le		Apri			995	2:25 P M
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (h	In yrs. lest bir		UNDER 1 YEA		R 24 HRS.	7. DATE OF I	BIRTH IV. Weet		6. BIRTH	PLACE (State or Foreign
Ð		213-48-55	61	1 🗆 M 2 🔀 F	8	8	YRS.	THE DAY	HOURS	MIN.	7/29	9/19	06	Sno	w Hill, Md.
3 should		99. FACILITY NAME (If not in	stitution, give st	treet and number)			9b.	CITY, TOW	N OR LOCAT	ION OF D	EATH		9c. COU	NTY OF O	EATH
2.3	6	Berlin Nu	rsing	& Reh	ab.C	ente	r	Berl	lin				N.	orce	ster
- -	[[[RESIDENCE OF DEC	10b. COUNTY	,											
Page	DIRECTOR					1 "	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?
E.		Md.	V	lorcest	er		Snow Hill								1 X YES 2 NO
physician. burial-transit permit. Pages	FUNERAL		1. 7. 1	01.					10f. ZIP COD						HAT COUNTRY?
frans	Ä	111 Fran	IKIIN						218					.S.A	
physician. burial-trar		t Never Married 2	Merried	12. WAS DECEDENT FORCES? 1	YES	2 NO	•	If yes,	specify Cub	en, Maxice	NIC ORIGIN? (S on, Puerto Rice	pecify Yee n, atc.)	or No-	14. RACE Black	— American Indian, , White, etc.
	ਨੂ	3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DA	TES		1 🗆 1	ES 2 XNO	Specif	y:			Specif	
as as		15. DEC	EOENT'S EDUC	CATION		16e. DECED	DENT'S USU	AL OCCUP	ATION	_	165 KIN	OF BUS	INCO INC	DUCTOV	white
. 6		(Specify only Elementery/Secondary (0	y highest grade			(Give k	kind of work of NOT use ret	done during	most of work	ing	TOD. KIN	0 01 003	111/23/1112	703 INI	200
हैं हैं।	<u> </u>	11	F12)	College (1-4 or 5	*'	Но	mema	ker						าพท	home
the hospit detached once.	COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)						16. MOT	HER'S NA	ME (First, Midd	le. Maiden :		J 11 11	TOME
8 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	<u></u>	William T	. Hea	arne					100		y Jone			re	
retained 5 should notified	00	19e. INFORMANT'S NAME (7				19b. M.	AILING ADD	ORESS (Stre			Route Number, (
5 5	2	Ann Wilco	×												21863
may be or, page st be		20a. METHOD OF DISPOSIT	ION		20b.	PLACE AND					OATE	_		City or To	
5 G 0		1 XBuriat 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other		oval from State		th a to			Co	mo+	1				
Page al dire		4 Donation 5 Other (Specify) What coat Meth. Cemet. 4/22 Snow Hill, Md. 2186. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
death. Pag funeral di examiner		Hate	4.0	1 11	2	2011		,	lonni	c E:	120000	1 11 -		C	בא ווגוו
the wal.		Villa	ceso	01-000	en	ni	2								Hill, Md.
S = P		23. PART I. Entar the di shock, or h	iseeses, or c aart fellure. I	complicetione the List only one cer	et caused use on aa	tha deeth ach lina.	. Do not a	entar tha	moda of dy	ring, suc	h as cardiac	or reepi	ratory ar	rest,	Approximate Interval Between
filled i	i I	IMMEDIATE CAUSE (FIR					0			n 1	14.	_			Onset and Death
- > = =		resulting in death) a. Psuedomembranous Calitis, Senere i monthe													
ompletel		disease or condition reaulting in death)													
	Z	Sequentially list conditions, a class trickium difficile Celities 1 month													
e be execut sician and c prior to buri traumatic	CERTIFICATION	If any, laeding to immediate													
physician prosician prior i	[일	Cause. Enter UNDERLYING CAUSE (Disease or Injury													
of die	Ē	that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
E 5 - 6	岗			d											
= 본호를		PART II. Other significa	nt condition	s contributing to	deeth bu	ut not raau	ilting in th	na undariy	Ing cauea	given in	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
that that bd b	EDICAL	Right ?	Lever	er Lob	le 1	Fre	um	mi	tis			PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
sign Heal	밀	Seizu		isarde			1 TYES						ES 2 NO OF DEATH?		
been t. of		7								_	-				1 TYES 2 X NO
las Dep	SICIAN:	25. WAS CASE REFERRED TO	O MEDICAL					26	PLACE OF I	DEATH /Ch	eck only one)				
F ## 5	Sic	EXAMINER? 1 YES 2 X NO		HOSPITAL:	FR/Outon	ationt 2 1	Q7				6 Other (Sp	- 74.1			
SICIA certil	PHY	27. MANNER OF DEATH		28e. DATE OF			8b. TIME OF		INJURY AT	esidence	26d. DESCRI		LILIDY OC	CUBED	
this wit			Pending	(Month, E	Day, Year)		INJURY		WORK?	NO.	200. 5200111	DE 11011 II	100111 00	DUNED	
After death	BY	3 Culaida	Investigation	28e. PLACE C	OF INJURY .	— At home.	farm, street				261. LOCATIO	N (Street a	nd Number	or Burni G	Inute Mumber
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the Siz 1 28 is marked, or lit			Could not be determined	building,	etc. (Specia	ffy)	, , , , , , , , , , , , , , , , , , , ,	.,, .	.,,,,		City or To	wn, Stete)	no nomos	Or North P	sute Number,
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	91	29a, CERTIFIER													
= 24 P	COMPLETED	(Check only		CIAN: To the best of											
TO THE HOSPITAL TO THE FUNERAL De filed within 72 t	$\bar{\aleph}$				xamination	end/or Inve	stigstion, in	my opinior	i, death occu	red at the	time, date and	place, end	d due to th	te Cause(e)	end menner ee stated.
THE F	BE	29b. SIGNATORE AND TITLE	OF GERTIFIER	D	0	7	0.	(ENSE NUI			29d, DAT	E SIGNED	(Month, Day, Year)
5 5 3 W	10	rego	en k	4.10	ello	and .	Me	1		29505			1	- 2	0-95
		Gregorio Belloso, MD 4421 Beechwood Place Crisfield MD 21817													
	2	31. DATE FILED (Month, Day,	Year)	32. REGISTRA		_					OLIGI	LULU		۷. ۱. (
		APR 2	2 1 199	5 Julia		and for	مالمال								



TO THE HOSPITAL OR ATENDING PHYSCLAN. The law requires that the death certificate be escuted withing a four after death. Page 6 may be retained by the hospital or attending physician.

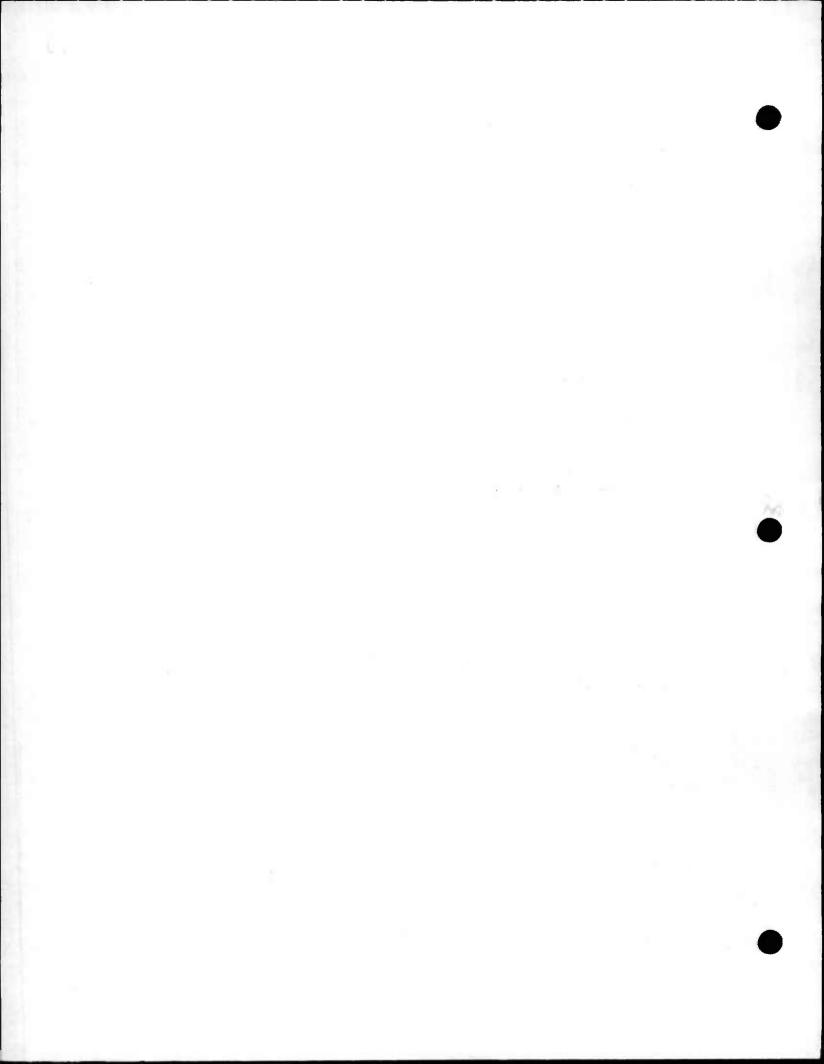
TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and competiny filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be flud within 72 hours after death with the State Days, or Health and Mental Hydrons prior to berial, cremation, or removal.

IMPORTANT: If them 28 is marked, or flow 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR
	- STATE REGISTI
	1. DECEDENT'S
	CH
	4. SOCIAL SEC
	218-2
	9a. FACILITY N
	Washi
ľ	RESIDENC
ı	10a. STATE
	Maryl
ľ	10e. STREET A
	6803
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

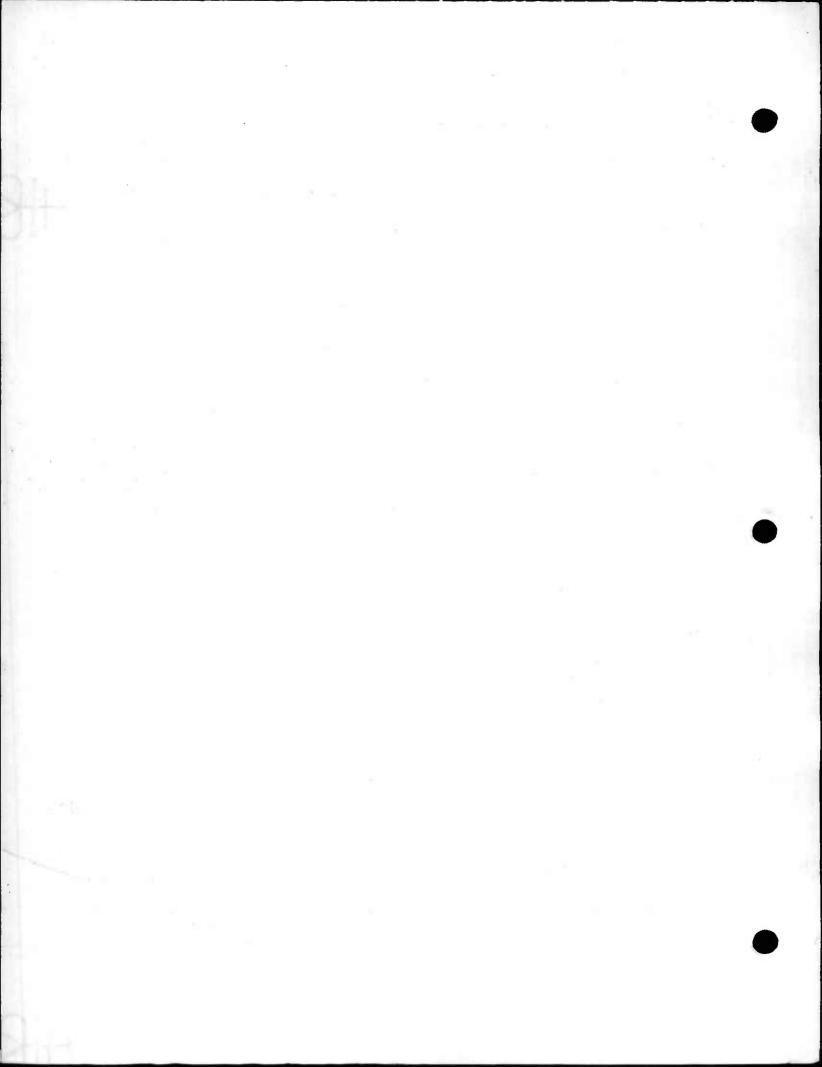
	REGISTRAR			ERITE	CALE	IF DEAL	Н	REG. NO	ł.			
	1. DECEDENT'S NAME (First, Middle, Last)	0						DATE OF DEATH	AY	YEAR	3. TIME OF DEATH	
	CHARLES	13RYA		116	CFF 6	FR		PRIL 8	9	1995	0500 M	
	4. SOCIAL SECURITY NUMBER		S. AGE (In yrs. Is		MONTHS DA			OATE OF BIRTH (Month, Day, Year)	,	8. BIRTI	IPLACE (State or Foreign	
	218-24-2281	1 🕅 M 2 🗍 F	62	YRS.		NOONS			1932	32 Maryland		
_	9a. FACILITY NAME (If not institution, give str				9b. CITY, TO	VN OR LOCATIO	N OF DEATH	1	9c. CO	UNTY OF D	EATH	
6	Washington Advent	ist Hosp	<u>i</u> tal		Takom	a Park			Mor	itgom	ery	
[[RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CITY	TOWN OR 1	CATION					444 1110105 01714	
E	Maryland Prince	George's	_		10c. CITY, TOWN OR LOCATION Seabrook						10d. INSIDE CITY LIMITS?	
ادِ	10e. STREET AND NUMBER	George :	5	Seal	JIOOK	10f. ZIP CODE			1 YES 2 NO			
RA	6803 94th Avenue					20706			17.	A.	WHAT COUNTRY?	
BY FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN II S. A	DMEO	12 WMC			ORIGIN? (Specify Ye				
F	1 Never Married 2 X Married	FORCES? 1 X	YES 2	NO	If yes	, specify Cuban,	, Maxican, P.	uarto Rican, etc.)	a or No—		E — American Indian, k, Whita, etc.	
	3 Widowed 4 Divorced	17 123, GIVE 184	ON DAIES		'	YES 2 X NO	Specify:			Spec	White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. D	ECEDENT'S	USUAL OCCU	ATION		16b. KIND OF BU	SINESS/IN	IOUSTRY		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	- iii	e. Do NOT us	ork done dunn e retired.)	most of working	,					
MP	12		Fra	ame Ma	an			C & P 7	elep	hone		
8	17. FATHER'S NAME (First, Middle, Last)	-		-		18. MOTH	ER'S NAME	(First, Middle, Maiden				
BE (Jacob B. Huffer					Elsi	le L.	Boteler				
5	19a. INFORMANT'S NAME (Type/Print)		1	Db. MAILING	AODRESS (Str	et and Number o	or Rural Route	e Number, City or Tox	vn, State, Z	ip Code)		
-	Joan P. Huffer			5803	94th A	venue,	Seabr	ook, Mar	ylan	d 20	706	
	20a, METHOD OF DISPOSITION 1 \(\text{L} \) Burtal 2 \(\text{L} \) Cremation 3 \(\text{L} \) Remove	vel from State	complease or	ametan, or of	F DISPOSITION					- City or To		
	4 Donation 5 Other (Specify)		Fort	Linco	ln Cer	netery	04/10	/95 Bre	ntwo	od, l	Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			22. NAM	E AND ADORES	S OF FACILIT	TY				
	W.3 6							Sons Fu				
	23. PART I. Enter the diseases, or co	emplications that of	aused the d	eath. Do n	ot enter the	mode of dvin	inore	Ave., ny	iratory a	VIII	Approximate	
	snock, or neart fellure. L	ist only one cause	on each iin	0.		1		1		,	Interval Between Onsat and Death	
	IMMEDIATE CAUSE (Final disease or condition											
ł	resulting in death)	DUE TO (O	R AS A CONSE	QUENCE OF	Y 1	YM	IVA	u			171	
_											200	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSE	QUENCE OF	. 1						1	
8	cause. Enter UNDERLYING CAUSE (Disease or Injury										1	
<u> </u>	that initiated events	ents DUE TO (OR AS A CONSEQUENCE OF):										
8	resulting in death) LAST d.										1	
2.4	PARE II. Other significant conditions	contributing to de	ath but not	mantting is	the under	don canada	ump in Bust	1 Tata man and	ALFRONEN	d.		
EDICAL	MUHUMA	1 Sun	HI.D	In	R	MAN IN	N+ 10	1. 24s. WAS AN PERFOR		/ 246	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
۵	The Harman	2 1	341	101	11112	7100100	AL.	YES 1	NO		OF DEATH?	
Σ	DID TORACCO HEE CONTROL				we	_	y	4			1 TYES 2 NO	
A N	DID TOBACCO USE CONTRI	BUTE TO CAU			H (Check only o		RIAIN					
泛	EXAMINER?	HOSPITAL:			OTHER:							
PHYSICIAN:	27. MANNER OF DEATH	Inpatient 2 . E		-		fome 5 Resi						
	1 Natural 5 Pending	(Moreth, Day)		286. TIME INJU	IRY	INJURY AT WORK!		t. DESCRIBE HOW I	NJURY OC	CURED	- 1	
à	2 Accident Investigation 3 Suicide & Could out be	28s. PLACE OF I	NJURY At h	ome form of		YES 2		LOCKTON IN-				
	4 Homicide 4 Could not be	building, sto	L (Specify)	Arrian marine, an	rees, technicy, t	TING .	200	City or Town, State)	and Murrios	r or Hunu A	DUM NUMBEC	
9 1	29a. CERTIFIER		4. = -V/VV	10000								
₫ II	Check only 1 CENTIFYING PHYSICI											
COMPLETED	2 MEDICAL EXAMINER	on the party of easy	milation and/or	- Conventigation	in my openia	c death occured	d at the lime	, date and place, an	d due to t	he ceuse(e	and manner se stated.	
H H	SHI SIGNATURE AND TITLE OF CENTIFIER	1 1	MAN.	DU	Y	23 CICEN	SE HAMMEN	CA	294. DA	ESIGNED	Magar Disk Mary	
٩	WW WW	1144	NA.	7	1 0	10	LY	10	PU	ypr.	8,1991	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH HTE	M 27) /3pe.	Printi			-		1		
- 11	110 / - 1111	1 11 1	/ 4/									
	31. DATE FILED (Month, Pro. Mar) APR 10 1995	JE PEGISHAN	MIS							•		



BALTIMORE, MARYLAND 21215-0020

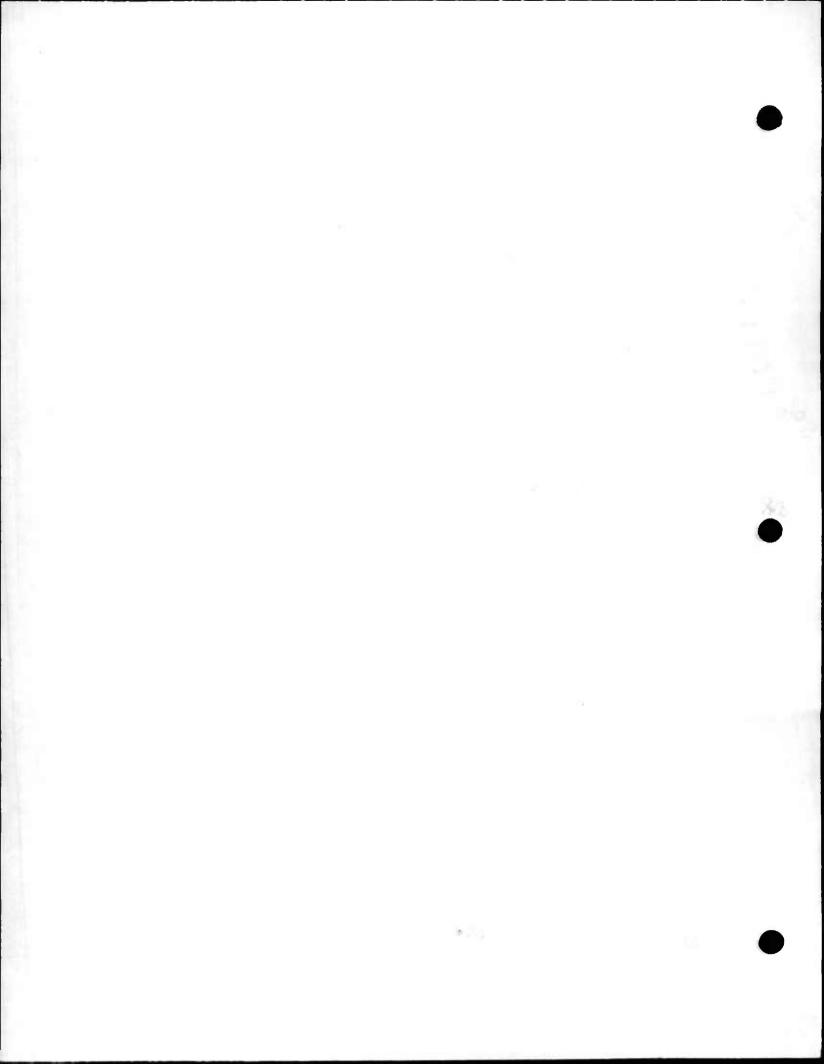
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN	_		
ļ	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY VEAR 3. TIME OF DEATH			
	Brian Kennard Henderson 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF			IF UNDER 1 YEAR IF UNDER 24 HRS.	April 6,		13:00 IRTHPLACE (State or Foreign	
	579-90-5538 9a. FACILITY NAME (If not institution, give	1X M 2 F	19 YRS.	ONTHS DAYS HOURS MIN.	May 21,	1975	G.Co. Md	
BO BO				b. city, town on Location of I Lexington Park				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY		TOWN OR LOCATION			10d. INSIDE CITY	
		Mary's	Lex	ington Park			LIMITS?	
FUNERAL	10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2823 Hilton Drive 20653 United State							
ONE	2823 Hilton Driv	12. WAS DECEDENT EVER I		2065	ANIC ORIGIN? (Specify Ye	s or No.— 14, 1	RACE — American Indien.	
B≺	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 1 YES		If yes, specify Cuban, Mexic 1 YES 2 NO Spec			Black, Whita, etc. Specify: Black	
ETED	15. DECEDENT'S Et (Specify only highest gra	DUCATION de completed)	18a. DECEDENT'S US	SUAL OCCUPATION rk done during most of working retired.)	16b, KIND OF BL	JSINESS/INDUSTI	RY	
IPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		elivery	Nelin	0.00		
COMPL	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surraggle)							
BE	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDR			RESS (Street and Number or Pural Poute Number, City or Fown, State, Zio Code)				
욘	Brenda Henderson 2823 Hilton Dr. Lexington Park, Md. 20653							
	20a. METHOD OF DISPOSITION 1 Burial 2 X Cremetion 3 Re	moval from State 20t	D. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LO	OCATION — City	or Town, Stata	
). Th	1 Burlai 2 N Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY							
	Capitol Mortuary 1425 Maryland Ave., N.E. Wash. D.							
CERTIFICATION	snock, or heert failure IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bDUE TO (OR AS A		12 TO TO	e Head		intervel Betwonset and D	
MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the u					RMED3	24b. WERE AUTOPSY FINDI AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 1 NO	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)							
PHYSICIAN:	EXAMINER? 1 N YES 2 NO HOSPITAL: 1 I npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)							
100	27. MANNER OF DEATH 1 Neturel 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	RY WORK?	26d. DESCRIBE HOW	INJURY OCCURE	9	
ED BY	2 Accident Investigation Inves				ory, office 281. LOCATION (Street and Number or Rural Route Number, City or Rown, State)			
LET	29a. CERTIFIER 1 CEPTIFYING BLYCHOLD IN TO ME							
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner ea stated. MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner ea stated.							
BE C	296. SIGNAFURE AND TITLE OF CERTIFIER			29c. LICENSE NU	IMBER	29d. DATE SIG	NED (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pr			D14285		▶ 7 Ap	7 April 1995	
	William D. Boyd II. M.D., 17 Jefferson Street, Leonardtown, Maryland 20650 31. DATE FILED (Month, Day, West) 32. REGISTRAR'S SIGNATURE ADD 19 1905							



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

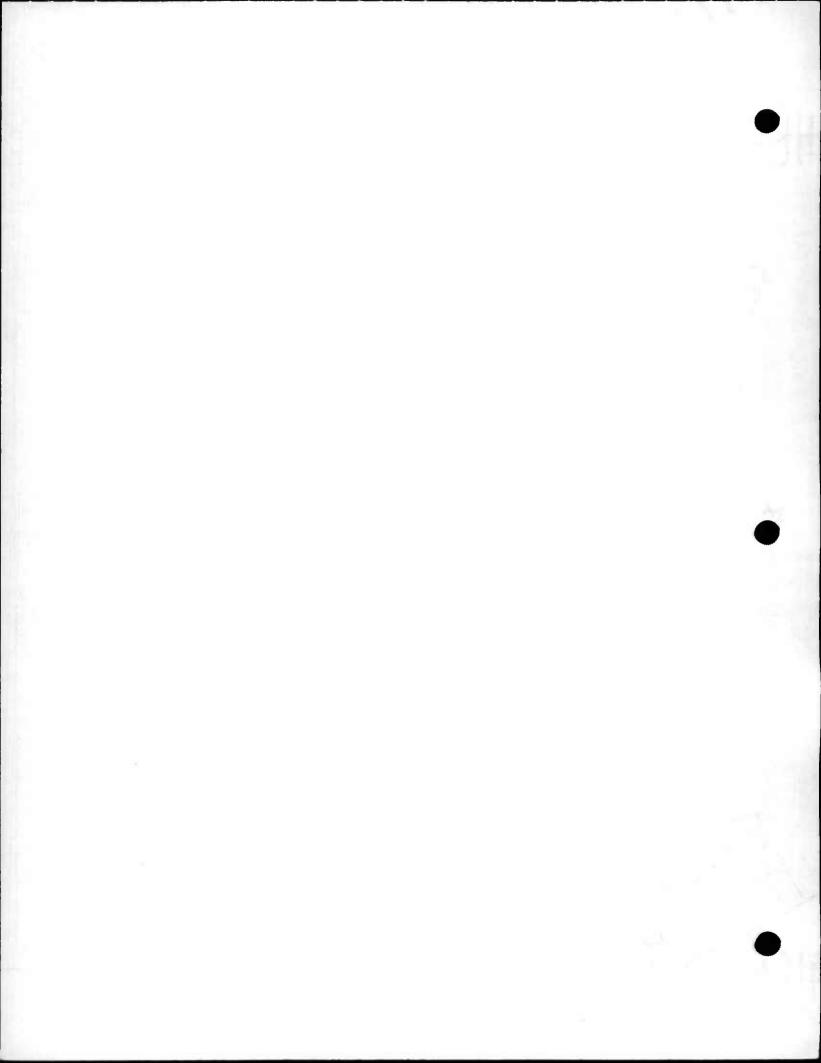
	3	1. DECEDENT'S NAME (First	, Middle, Last)				·		DCA		2. DATE OF	DEATH			3. TIME OF DEATH
		Lenice Elva	Lane	1	•					MONTH DAY YEAR April 5, 1995			YEAR Q5	7:30 P. M	
		4. SOCIAL SECURITY NUMBER		5. SEX	Harding 6. AGE (In yrs.		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	, 19	8, BIRTHI	PLACE (State or Foreign
77		577-18-983	5	1 🗌 M 2 💢 F	83	YRS.	MONTHS	DAYS	HOURS	MIN.	June		1911	Country	th Carolina
should		9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	, TOWN	OR LOCATION	ON OF DE				NTY OF DE	
2.3	[Washington	Adven	tist Hos	pital		Tak	oma	Park				Mon	tgom	ery
es 1.	DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	,		10c. CIT	Y, TOWN (OR LOCA	TION						10d. INSIDE CITY
ξ. 26	띰	Maryland	Princ	e George	t _S	Mt.	Rai	niei	r						LIMITS?
E	AL.	10e. STREET AND NUMBER						101. ZIP CODE					10g. CIT	HAT COUNTRY?	
an. ransit	FUNER	2903 Bunke	r Hill	Road					2071	12			S.A.		
hysici urial-t	豆	11. MARITAL STATUS 1 Never Married 2	Married	FORCES? 1	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO				CENDENT C	F HISPAN n, Maxical	iC ORIGIN? (C ORIGIN? (Specify Yea or No— 14. RAC Black)			- American Indian, White, atc.
the b	B∕	3 🕅 Widowed 4 🗌 Divo		IF YES, GIVE W	IF YES, GIVE WAR OR DATES			1 TYES	2 📉 NO	Specify				Specify	White
attend se as	8	15, DEC	EDENT'S EDUC	CATION	.16a,	DECEDENT'S	USUAL O	CCUPATI	ON		18b. KIND OF BUSINESS/INDUSTRY				
for u		Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT u	se retired.)	uunng m	OSL OF WORKIN	NG					
he hospi detached once.	COMPL	12			0	perato	r				_			hone	Company
by the		17. FATHER'S NAME (First, M William Th									ME (First, Mide		/	_	
ould to	띪	19a. INFORMANT'S NAME (7		ane		Charlotte Lottie Gentle									
s retained 5 should notified	유	Lynwood Ju		arding		19b. MAILING ADDRESS (Street and Number or Aural Route Number, City or Town, State, Zip Code) 24153 Lemay Street, West Hills, California								12 01307	
page page		20e. METHOD OF DISPOSIT	ION		20b. PLA	PLACE AND DATE OF DISPOSITION (Name of DATE 20c LOCATION						_			
ge 6 ma irector, p		4 Donation 5 Other	(Specify)		_ Fort	etery, cremetory or other place)						ntwoo	od, Maryland		
death. Pag tuneral dis I. examiner		21. SIGNATURE OF FUNERA	L SERVICE LIC		22. NAME AND ADDRESS OF FACILITY								0 TP A		
he fur		している	·Ge	Lies					eis Gasch's Sons Funeral Home, P.A. Baltimore Ave., Hyattsville, MD 20						
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should, or removal. medical examiner must be notified at once.		23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory erreat, shock, or heart failure. List only one cause on each line. Approximate Interval Between													
y filled in tition, or retied		iMMEDIATE CAUSE (Fine) disease or condition Cerebral vascular accident													
within and the state of the sta		resulting in death)	→ ,	1				iden	t						14
completel completel rial. crema			_		cal ble		F):								
ertificate be executed within 24 in ing physician and completely filled glene prior to burial, cremation, other traumatic event, the r	RTIFICATION	Sequentially list conditi		DUE TO	TO (OR AS A CONSEQUENCE OF):										
ysicia prior r trau	S	cause. Enter UNDERLYI CAUSE (Disease or inju	NG												
the death certificate be to the attending physician differential Hygiene prior injury, or other trau	E	that initiated events resulting in death) LAS	1	DUE TO	DUE TO (OR AS A CONSEQUENCE OF):										
he death certificate be to the attending physician Mental Hygiene prior to njury, or other traun	CER			l											-
		PART il. Othar aignifice	nt conditions	contributing to	death but no	t reaulting	in tha un	dariyin	g cause g	iven in i	Part i. 24	a. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
uires that the signed by the Health and In.	DICAL										_ 1	YES 2			COMPLETION OF CAUSE OF DEATH?
require sen sign of He	ME										_				T YES 2 NO
has b Dept.	AN	DID TOBACCO U		IBUIE TO CA		ACE OF DEAT			J UNC	ERTAIN					
HOSPIAL UR ALENDING PHYSICIAN: The law requires that EUNERAL DIRECTOR: After this certificate has been signed by within 72 hours after death with the State Dept. of Health an TANT: It Hem 28 is marked, or Item 23 shows any	HYSICIAN:	EXAMINER?		HOSPITAL:			OTHER	3:		ald					
d, or	Ϋ́	27. MANNER OF DEATH		28s. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	sidence	28d. DESCR		JURY OC	CURED	
NG PHYS fter this c eath with marked,	ВУ Р		Pending investigation	(Month, Da	ay, reer)	167	URY		YES 2	NO					
BR: Aff	ED E	3 Suicide 8	Could not be	28e. PLACE Of building,	F INJURY — At etc. (Specify)	home, farm, s	street, fact	ory, offic	•		28f. LOCATIO	ON (Street a	nd Number	or Rural Ro	ute Number,
L OR ALTENDING P DIRECTOR: After to hours after death item 28 is mari	E		datermined												
AL DIRE 72 hours 11 item	COMPLET	29a. CERTIFIER (Check only one)	IFYING PHYSIC	CIAN: To the best of	my knowledge,	death occurre	ed at the ti	lme, data	and placa,	and dua	to the cause(e) and men	ner as stat	ed.	
IN THE HOSPITAL THE FUNERAL METER WITHIN 72 F IMPORTANT: It I	00	2 MEDI		: On the beets of as	camination and/	or investigatio	n, in my o	pinion, d	leath occur	ed at the t	lme, data and	d placa, and	due to th	e cause(a)	and menner as stated.
DR 電車 量	BE	295. SIGNATURE AND TITLE	OF CERTIFIER		- (_			NSE NUM	BER		29d, DAT	E SIGNED (Month, Day, Year)
PRA	2											5,1995			
(2)															
9		Fayaz A. Shawl, M.D. 3001 Hospital Drive #H403, Cheverly, Maryland 20785 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DR 10 1995 July Dayslar Rowlett													
	·	DD 10 1995													
	178	11/ - 1000	0						_				_		



1 - FOR STATE REGISTRAR

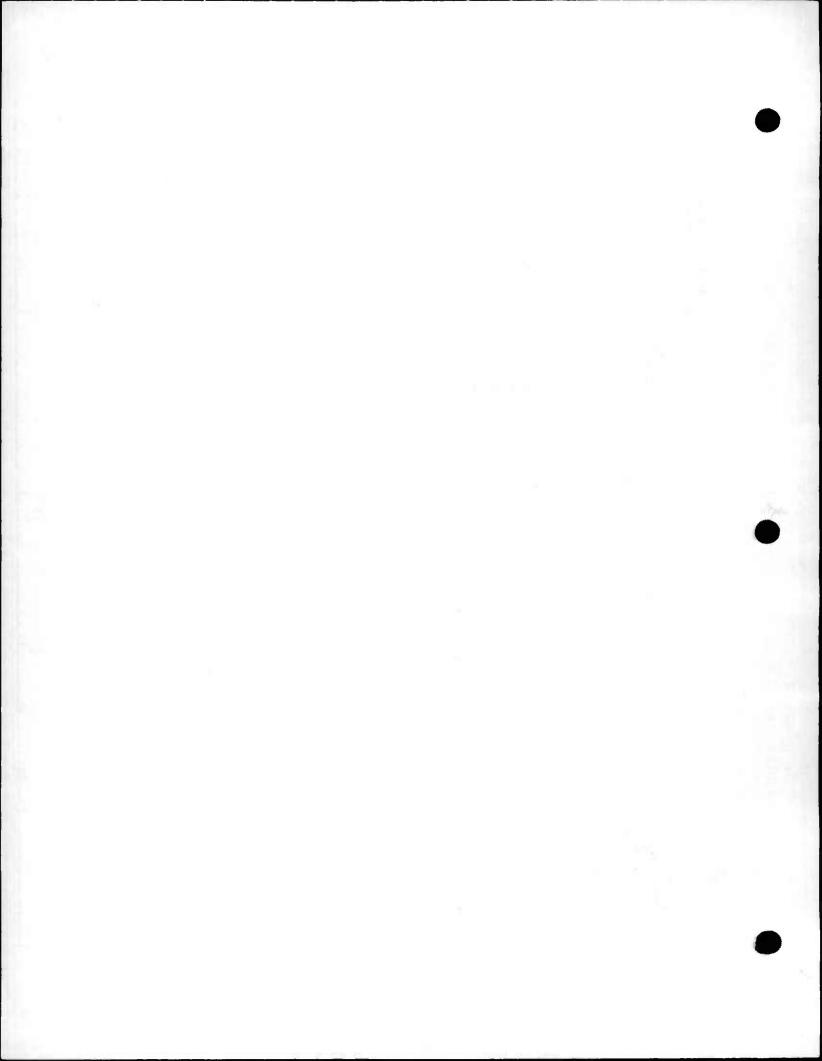
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

			7 EGIOTIVAT				CENTIF	ICATE	. UF	DEAL	П	REG. N	0.			
			1. DECEDENT'S NAME (First		_							2. DATE OF DEATH	DAY	YEAR 3	. TIME OF DEATH	
			ZE	MORIA	I.		HARRI	S				APRIL 3 1991			10:00 A M	
			4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in yrs.	last birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH		S. BIRTHPL	ACE (State or Foreign	
	,		578-22-12	50	1 🗌 M 2XXF	71	YRS.	MONTHS	DAYS	NOURS	MIN.	1/25/24	Į	Mar Mar	yland	
9 chould			9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN (OR LOCATION	ON OF DE			UNTY OF DEA	_	
		H.	Prince Geo	orge!	s Hosp	Cent	or	Ch	Cheverly				Prir	ice G	eorge's	
	:	DIRECTOR	Prince Geo			CCITE							1		corge 5	
Son		뿐	Md.	10b. COUNTY	P.G.			IO MWOT ,YT							Od. INSIDE CITY LIMITS?	
Paner Paner					r.G.			Blade	ensi	ourg				i	X YES 2 NO	
, and		ĭ¥.	10e. STREET AND NUMBER				101. ZIP CODE						10g. CIT	IZEN OF WHAT COUNTRY?		
020 physician. hunal-transit		FUNERAL		Anna	polis R	d. # 8	808							U.S.Z	Α.	
20 ysicia		5	11. MARITAL STATUS		12. WAS DECEDER	NT EVER IN U.S.	R IN U.S. ARMED 13. WAS DECENDENT OF HIS 2 NO 14 yes, specify Cuban, Ma					IC ORIGIN? (Specify)	es or No—	14. RACE -	- American Indian, White, etc.	
00		BY	3 Wildowed 4 Divo			MAR OR DATES		ï	YES	2XXNO	Specify				Black	
215-0020 attending physician					l			_ !							DIACK	
		ETED		EDENT'S EDU			(Give kind of	work done di	CUPATIO	ON ost of workin	g	16b. KIND OF B	USINESS/IN	DUSTRY		
		ᄬᅵ	Elementary/Secondary (0)-12)	College (1-4 or 5	+)	life. Do NOT u						_			
AND the hospital	6	COMPL	12th				File	Cler	k			U.S.		rnmer	nt	
A a a	at once.		17. FATHER'S NAME (First, M				18. MOTHER'S NAME (First, Middle, Malden Surname)									
R YL		H	William		Harris		Ida V. Bell									
MARYLAND retained by the hospit 5 should be detached	notified	6	19a. INFORMANT'S NAME (19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
			Ida V. Harris Same as # 10 above													
ALTIMORE, leath. Page 6 may be funeral director, same	12		20a. METHOD OF DISPOSITION 20a. METHOD OF DISPOSITION DATE DATE DATE 20b. PLACE AND DATE OF DISPOSITION (Name of camelon, crematory or other place) 20c. LOCATION — City or Town, State													
Page 6	Ē		4 Donation 5 Other (Specify) Mt. Olivet Cem. 4/7/95 Wash., D.C.													
F. Pa	nlne		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
BALTIMORE, ter death. Page 6 may be the funeral director, same	- 6		H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.													
urs afte	dic		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between													
thou a	i o		IMMEDIATE CAUSE (Fir		A					n	_	-			Onset and Death	
il Vie	nation,		disease or condition resulting in death)	→	KES	PIRF	470P	4	1	-AID	UR	E			>30-days	
60 with	I. crema	1	in doubly		DUE TO	(OR AS A CONS	SEQUENCE O	E.		1	1		1		1	
6876C ecuted wit		Z	Consumable Hot are also		SP-	Adu	Ut F	2089)	dis	gres	s ym	dra	my.		
	traumatic	CATION	If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												3- day	
m = 15	prio	2	CAUSE (Disease or Injury												270 mark	
O. E ertifica ing ph	용형	RTIFI	that initieted evente resulting in death) LAST													
ath c	e Hy	CER	a 110- Duyus													
CORDS, res that the de igned by the a	th and Menta any Injury,		PART II. Other significe	nt condition	e contributing to	deeth but no	t resulting	in the und	ierivino	n cellee o	ilven in I	Part I 24- MRC A	N AUTOPSY		ERE AUTOPSY FINDINGS	
hat th	and I'd	DICAL	HTN	510-	CYSTOC	Janny		rad		6-	Pat.	O PERFO	ORMED?	AN	MILABLE PRIOR TO DMPLETION OF CAUSE	
RECOR requires that	Health a	AED!	Polie	2	rach - 3	MIN.	-		2	141	404.0	1 TYES	2 000		F DEATH?	
A requirements	5 5	-	DID TOBACCO U		-	LICE OF DE	CATU M	· ·	IO F	1 10.00	FDTAIL	155	(1	YES 2 NO	
as a	S G	PHYSICIAN	25. WAS CASE REFERRED TO		CIBUIE TO CA		ACE OF DEA		_	UNC	ERTAIN	1 138(NIT	
		Ö	EXAMINER?	O MEDICAL	HOSPITAL:			OTHER:								
F VIT. SICIAN: TR certificate	e &	¥	27. MANNER OF DEATH		1 Onpetiant 2 28a. DATE OF		3 LI DOA			URY AT	sidenca	B Other (Specify)				
PHYS O	te de		b	Pending	(Month, C		IN.	IURY	WO	SMT		28d. DEŞCRIBE HOW	INJURY OC	CURED		
		B		Investigation	260 PLACE C	SINJURY — At	hama fami		£	rES 2	NO					
VISION ATTENDING ECTOR; After		8		Could not be determined	building	atc. (Specify)	nome, term,	erreet, taeto	гу, опис	•		281. LOCATION (Street City or Town, State	and Number	r or Rurai Roul	te Number,	
00 00	hours a	<u> </u>	29a. CERTIFIER				-									
	원보	4	(Check only									to the cause(a) and m				
HOSPITAL FUNERAL		COMPLETED	2 MEDI	CAL EXAMINE	R: On the basis of a	xamination and/	or investigation	on, In my op	inlon, d	eath occur	ed at the t	lime, data and placa, a	ind due to ff	he cause(a) ar	nd manner as stated.	
五	* 1	ш	29b. SIGNATURE AND TITLE	OFCHTIME	000	^				29c. LICE	NSE NUM	BER	29d, DAT	E SIGNED M	onth, Dage Year)	
PE B	be fled within IMPORTANT	0 0		00	Mesoy	S				D-3	4.	122	1 × f	HMM-	-4th-95	
/	1	٩	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH (IT	тем (7) (Турь	Print)	_	1	. ~			0	, , , ,	
			5.7. Las, Ms - 4000- Mitchelville Read; # 220; BOWIE-MD-20716.													
			31. DATE FILED (Month, Day,	F	32. REGISTRA	R'S SIGNATURE										
	- 1		APR 1 0 199	5 Su	las Davelin	12/0 1 19										



ITEMS: 23 PART I, II, 27, PER MEO FILM G-723 5/19/95 t.t

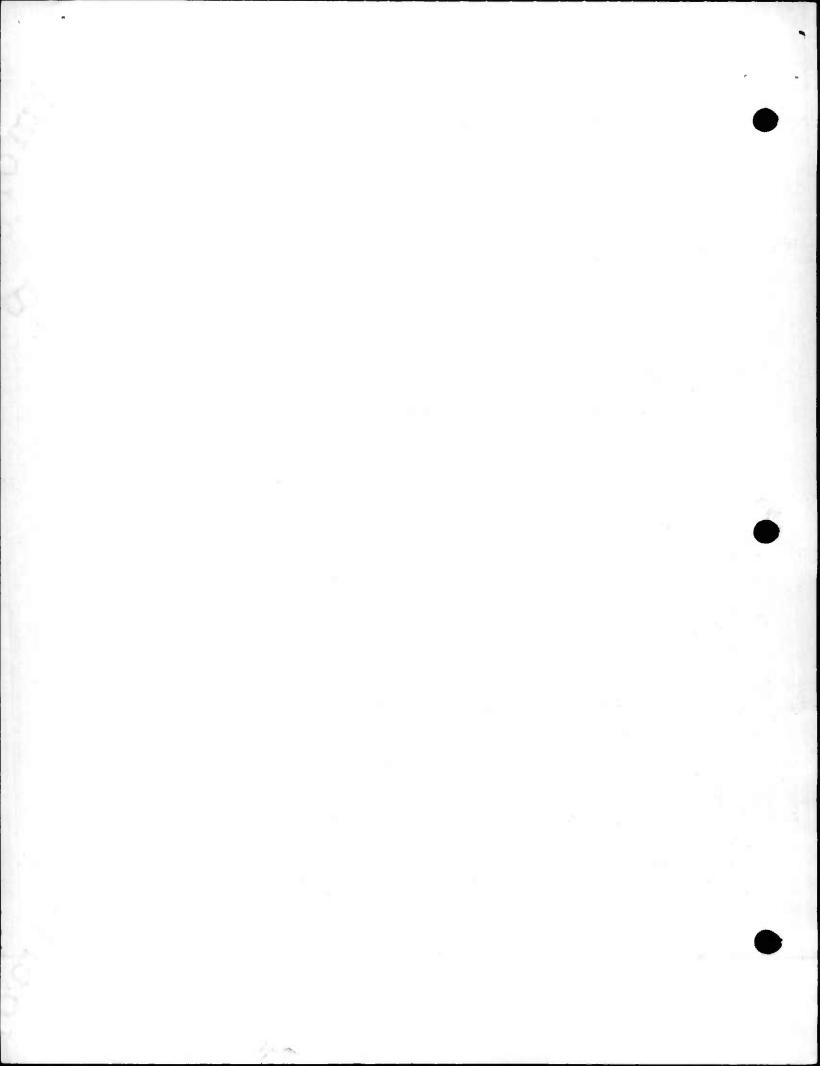
	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIFI	TMENT OF H	IEALTH AND I	MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Last) RONNIE HEBR(9 19	YEAR	IME OF DEATH 9:45 P M			
	4. SOCIAL SECURITY NUMBER % 578-72-1677 90. FACILITY NAME (If not institution, give	1 XM 2 □ F 3	yrs. last birthday) 9 YRS.	IF UNDER 1 YEAR MONTHS DAYS 9b. CITY, TOWN (IF UNDER 24 HRS. HOURS MIN. DR LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year) July 20	,1955	BIRTNPLACE	E (State or Foreign ington, DC			
TOR	PRINCE GEORGES	HOSPITAL C	ENTER	CHEVE	RLY		PRI	NCE (GEORGES			
	10a. STATE 10b. COUNT	TY .		nowhor Locateshington	n, D.C.			1%	INSIDE CITY LIMITS? YES 2 NO			
ERA	106. STREET AND NUMBER 1063 44th. Str	eet.N.E. #B		101	20019			S.A.	COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 ₩ NO	If yes, sp					mericen indien, ite, etc.			
TED	15. DECEDENT'S EDI (Specify only highest grad	JCATION 10 completed)	16a. DECEDENT'S I	ork done during ma		16b. KIND OF BU	JSINESS/INDU			+		
than 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. "LETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	sabled								
SO	17. FATHER'S NAME (First, Middle, Last)				Surneme)							
BE	Robert D. Heb:	ron	105 MAILING	ADDRESS /Street of		se Holida				_		
유	Carloyn Hebron					washington, D.C.,20019						
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	novel from State 20b.P	LACE AND DATE O	F DISPOSITION /Na		DATE 200 LG	dover,	ty or Town, St				
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	mony ner		D ADDRESS OF FAC	ILITY				1		
	W. J. (leppere		389 Rh	ode Isla	Frazie nd Av.,NW	.Washi	ngton.				
CERTIFICATION	immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	B. HYPERTENSIVE AR DUE TO (OR AS A C	TERIOSCLEI OMBEQUENCE OF	ROTIC CARC	DIOVASCULAR	DISEASE		-	Approximate Intervel Between Onset and Death			
MEDIC	PART II. Other significant condition HEALED ENDOCARDITI	S, MITRAL VALVE W	ITH REGUR	GITATION		YES :	RMED7	COMP OF DE	AUTOPSY PINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO			
IAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		UNCERTAIN					ł		
YSIC	EXAMINENT 1 X YES 2 □ NO	HOSPITAL: 1 ☐ Inpetient 2 XER/Outpeti		OTHER: 4 [] Nursing Home	s 5 □ Residence 6	Other (Specify)				١		
	27. MANNER OF DEATH 1 Whatural 5 Pending 2 Accident Investigation	(Morth, Dec. Wer)	28b. TIME INJU	RY WO	JRY AT RK7 'ES 2 NO	28d. DESCRIBE HOW	INJURY OCCU	NED		١		
	3 Suicide & Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, si	rest, factory, office		28f, LOCATION (Street City or Town, State)	and Number or	Plure! Ploute N	lumber	١		
MPLE		ICIAN: To the best of my knowled ER: On the gesis of examination a							manner se stated.	١		
D BE CO	296. SIGNATURE AND TITLE OF CERTIFIE		111		29c. LICENSE NUM			HGNED (Month	Committee Committee	ł		
10	30. SAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF BEAT	H (ITEM 27) (Type, I	Scions	O.C.M.	E	MAI	RCH 3	0,1995	1		
	31. DATE FILED (MUNIN, DINK WAN)	132 REGISTRAP S BONAT	11 PENN		T, BALT	IMORE, MA	ARYLA	ND 21	201			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	IU THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1. 4

	1 - STATE REGISTRAR	STATE OF MAR			OF HEALTH AND	MENT	REG. NO					
70	1. DECEDENT'S NAME (First, Middle, Last)) He	LM	4N			TE OF DEATH	~29	23	20/pm		
	4. SOCIAL SECURITY NUMBER 135-36-6728	5. SEX 6. AI	GE (In yrs. lest birtho	MONTHS	TYEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DA (M) Ju	July 30, 1943			Ville, Va.		
	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY,	TOWN OR LOCATION OF				TY OF DE			
OR	Mercy Medical Ce	nter		Ва	ltimore							
딚	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ν	100	CITY, TOWN O	D I OCATION			10d. INSIDE CITY				
DIRECTOR	Virginia	•		ichmon	2777				LIMITS?			
	10e. STREET AND NUMBER			TCIIIIOI	101. ZIP CODE			HAT COUNTRY?				
ER	2903 E. Marshall	Street			23223							
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 XNO	1 1	NAS DECENDENT OF HISP I yes, specify Cuben, Mexi	can, Puar		or No-		— American Indian, White, atc. :: Black		
E E	15. DECEDENT'S EDU (Specify only highest grad		16a. DECEDER	IT'S USUAL OC	CCUPATION furing most of working		18b. KIND OF BU	SINESS/IND	USTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do No	OT use retired.)						7.5		
MP	17. FATHER'S NAME (First, Middle, Last)		I.	lechani			Privat					
	Maynard Ross Holm											
BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
2	Louise Holman 2903 E. Marshall St. Richmond, Va. 23223											
	20s. METHOD OF DISPOSITION X 20s. METHOD OF DISPOSITION X 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION — City or Town, S											
			cemetery, crematory Oak	or other place)	Cemetery	3	/2 Ric	hmond	l, Va	•		
	21. SIGNATURE OF PUNERAL SERVICE LI	CENGEE	-	22,)	NAME AND ADDRESS OF	PACILITY						
	- (ly/on)	Cayon		> P1	unkett Fund	eral	Home,	Wash.	, D.	С.		
CERTIFICATION	23. PART Leritar the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other aignificant condition					in Part I.	PERFOI	RMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CAOOL		28. PLACE OF DEATH (
Sign	1 TES 2 NO	HOSPITAL:	Outpatient 3 DO	OTHER A 4 Nurs	t: ling Home 5 - Rasidenc	6 0	ther (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJUI (Month, Day, Yea	RY 26b.	TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. (DESCRIBE HOW	NJURY OCC	CURED			
red BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined	26s. PLACE OF INJU building, atc. (5	JRY — At home, to Specify)	rm, street, facto	ory, offica	281. L	OCATION (Street lify or Town, State)	and Number	or Rural Ro	oute Number,		
COMPLETED		SICIAN: To the best of my kr								and menner as stated.		
U U	29b. SIGNATURE AND TITLE OF CERTIFIE			-	29c. LICENSE N					Month, Day, Year)		
TO B	30. NAME AND ADDRESS OF PERSON WI	OCCUPLETED CAUSE OF	DEATH (ITEM 27)	Type, Print)	Dr. Dine	3-55	mb	> 3	129	195		
	31. DATE FILES (Month 995°)	La dieschana	KANATORE									



FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	C	ERTIFIC	ATE OF	DEATH	REG. NO							
	1. DECEDENT'S NAME (First, Middle, Last) EDWIN	DONALD		HARTI	MAN MEN, SR.	2. DATE OF DEATH MONTH DA	19 95	3. TIME OF OEATH 11:15P M					
	4. SOCIAL SECURITY NUMBER 212-24-2207	5. SEX 6. AGE (in yrs. las		UNDER I YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1	929 6. BIRT Coun	HPLACE (State or Foreign try) ARYLAND					
DIRECTOR	9a. FACILITY NAME (# not institution, give str 11316 VALLEY	ROAD, N.E.	96		ERLAND		9c. COUNTY OF I	DEATH					
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	TION			10d. INSIDE CITY					
	MARYLAND ALL 10e. STREET AND NUMBER	EGANY	CUI	MBERL	A N D			LIMITS? 1 TES 2 NO					
FUNERAL	11316 VALLEY R				21502		10g. CITIZEN OF						
В	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 (X) YES 2 (1) N FYES, GIVE WAR OR DATES KOREAN CONFLI	MED IO CT	If yes, sp	ENDENT OF HISPAN ecify Cuban, Maxicar 2 X NO Specify	tC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	Blac	E — American Indian, k, White, alc.					
TED	15. DECEDENT'S EDUC (Specify only highest grade of	completed) (Gi	CEDENT'S USU	done during mo	ON st of working	16b. KINO OF BUS	SINESS/INDUSTRY						
COMPLETED	Elementary/Secondary (0-12) 12	College (1-4 or 5 +)	NER/OI	lined.)		GROCEF	RY STOR	E					
ш	17. FATHER'S NAME (First, Middle, Last) EDWIN BONNIE H	ARTMAN				AE (First, Middle, Maiden RET VIOLA	,						
TO B	19a. INFORMANT'S NAME (Type/Print) LINDA M. HARTM/					Noute Number, City or Town		,MD 21502					
	20a. METHOO OF DISPOSITION 1	20b PLACEA	MDDATEOF DE	SPOSITION /Na	me of	OATE 20c. LO	CATION — City or To	own, Stata					
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	EI MET	22 NAME AN	A AODDERE OF THE		IMBERLA						
	Mend 9. 4	expund		GEOR(202 (GE-UPCHU GREENE S	JRCH FUNE ST., CUMBE	RAL HOI	ME, P.A. MD 21502					
	23. PART I. Enter the diseasea, or ci ahock, or heart failure. L	implications that caused the de lat only one cause on each line.	eth. Do not	enter the mo	de of dying, auch	as cardiec or respi	ratory arrest,	Approximate interval Between					
8	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	Multiple ST OUE TO (OR AS A CONSEC	bb (nd	Cuttin	15 Wor	els	Onset and Death					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
EDICAL C	PART II. Other algolificant conditions	contributing to death but not re	eaulting in th	e underlying	cause given in f	Part I. 24e. WAS AN PERFOR	MED?	. WERE AUTOPSY FINDINGS AMAILABLE PAROR TO COMPLETION OF CAUSE OF DEATH?					
Σ	DID TODA CCO LICE COATTO	IDITE TO CALLES OF THE			1	^		TYES 2 NO					
AN	DID TOBACCO USE CONTR		TH YES [NO X	UNCERTAIN								
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	ОТ	HER:	s 5 ☐ Residence X	XX ber (Specific)	STORE						
五	27. MANNER OF OEATH	28a. DATE OF INJURY (Morth, Dayl Year)	28b. TIME OF	28c. INJI	JRY AT	28d. DESCRIBE HOW II		1.1					
BY	1 Natural 5 Pending 2 Accident Investigation	4/19/95	3305	M 1/X	ES 2 NO	Subject	SA	obed					
	3 Suicide 8 Could not be detarmined	26a. PINACE OF INJURY — At hor building, atc. (Specifi)	ne, ferm, street	S)	e E	281. LOCATION Street City or Town, Shire	nd Number or Rural	Poute Number,					
7	29a. CERTIFIER t CERTIFYING PHYSIC	IAN: To the best of my knowledge, das											
2	Marian Ma	to the besie of supplication and to a	mention in			time about and about							
COMPLETED	2XXMEDICAL EXAMINER	On the basis of axamination and/or t	iveatigation, in	my opinion, de			dua to the cause(s	s) and mannar as stated.					
8	SECRETURE AND TITLE OF CERTIFIER	vile M)			29c. LICENSE NUM	BER	29d. DATE SIGNED	(Month, Day, Year)					
ш		COMPLETEO CAUSE OF OBATH (ITEM	1 27) (Type, Print)	O.C.M.	BER	29d. DATE SIGNED APRIL	(Month, Day, Year)					

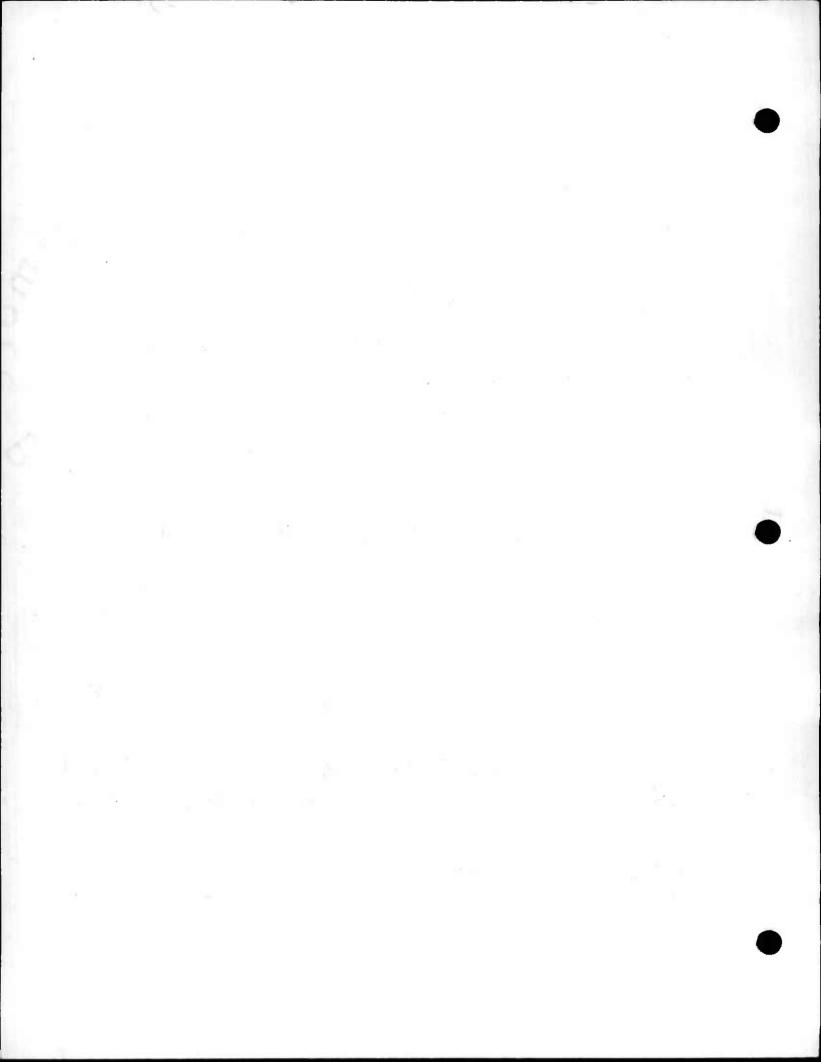
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

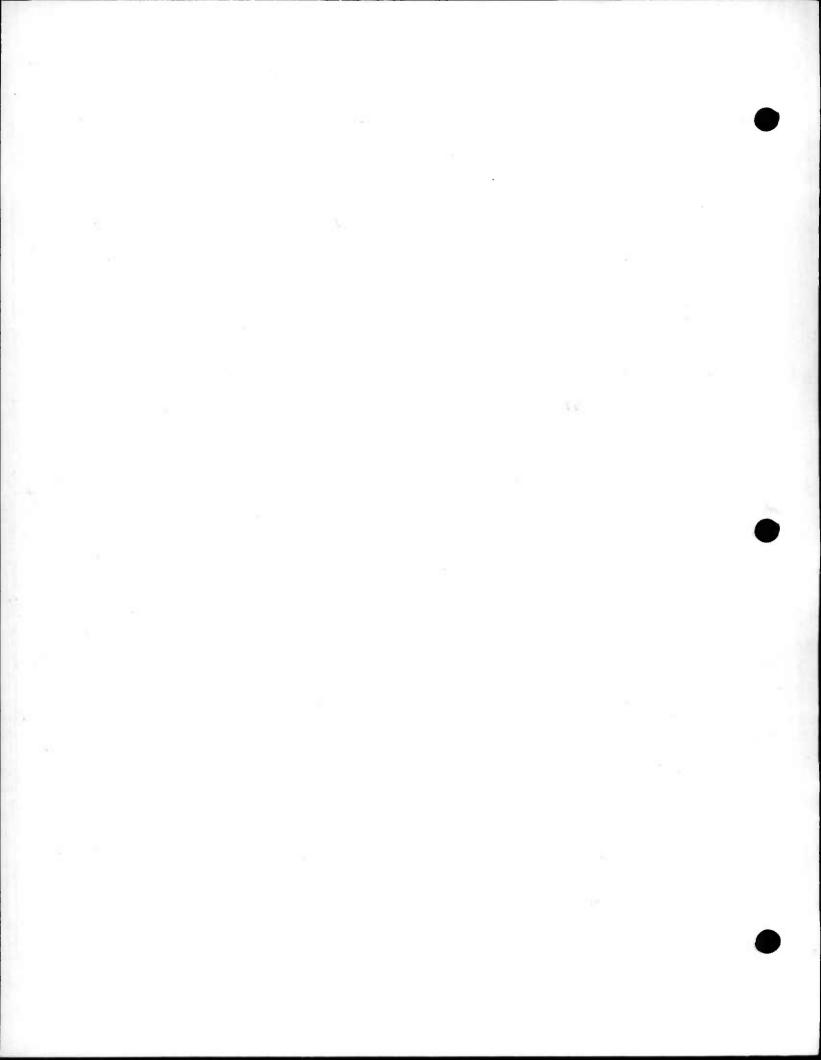
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



		REGISTRAR			CE	HIIF	ICALE	OF	DEAL	I H		REG. NO.				
		1. DECEDENT'S NAME (First,	Middle, Lest)								2. DATI	OF DEATH	Y	YEAR 3	. TIME OF DEATH	
		Mary		Clizabeth	1		Har	ncoc	ck		April 13, 1995 18:30 P.					
		4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1		IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTHPL	ACE (State or Foreign	
		219-14-50	40	1 □ M 2 X□X=	73	YRS.	MONTHS DAYS HOURS MIN. A Pr. 11, 1922						Peni	nsylvania		
3 should		9a. FACILITY NAME (If not in	stitution, give si	reet and number)										TY OF DEA		
	腾	CALVERT MEN	MORTAL	HOSPITA	1		PRI	NCE	FRE	NEDI	CK		CALV	EDT		
1, 2,	СТОВ	RESIDENCE OF DEC	EDENT		La.		PRINCE FREDERICK						CALV	ENI		
Pages	DIRE	10a. STATE	10b. COUNTY		1		Y, TOWN OF								Dd. INSIDE CITY LIMITS?	
- <u></u>	ā	Maryland	Princ	ce geor	ge s	C	apit	āl	Hei	ght:	S			1	YES 2 NO	
permit.	A	10e. STREET AND NUMBER				101. ZIP CODE							10g. CITIZI	EN OF WH	AT COUNTRY?	
işi.	FUNERAL	4802 Fabl	e Str	eet					207	43			U	. S . A	A .	
215-0020 attending physician. se as the burial-transit	5	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. W	AS DEC	ENDENT O	F HISPAN	IC ORIGI	N? (Specify Yea	or No — 1	14. RACE -	- American Indian,	
Phy Dury		1 Never Married 2			MAR OR DATES	0	"	yes, sp	2 X NO	n, Mexicar Specify	n, Puarlo	Rican, etc.)		Black, \ Specify:	White, etc.	
5-0020 anding physic as the burial	ВУ	3 X Widowed 4 Divo	rced	- 90	20.00				44	GP-03,				Openiny.	White	
	9	15. DEC	EDENT'S EDUC highest grade	CATION completed)	16a. DE(CEDENT'S	USUAL OC	CUPATIO	ON of working		16	. KIND OF BUS				
10 m	9	Elementary/Secondary (0		College (1-4 or 5	+)		work done du se retired.)					Air p			and	
The hospital or detached for u	COMPLET	l.		1	Acct	t.Re	c.Su	pei	rvis	or		chemi	cals			
AND he hospi detached once.	ő	17. FATHER'S NAME (First, MI										Middle, Maiden				
8 6 6 C	BE 0	William E	. Lau	terbach	l .				Ce	cel	ia 1	Cather	ine	Berg	gman	
MAKYL retained by the 5 should be notified at		19a. INFORMANT'S NAME (7)			196	. MAILING	ADDRESS	(Street a	nd Number	or Rural A	loute Nun	ber, City or Town	. State. Zip C	Code)		
45	유	Dorothea	Lyate	rbach	114	4922	Win	che	este	r R	d - C1	resapt	own,	MD	21502	
I IMORE, I. Page 6 may be ral director, page inner must be r		20a. METHOD OF DISPOSITI			20b, PLACEA	NODATE	OF DISPOSIT	TION (Ne	ome of		DA	E 20c 10c	CATION — CI	ity or Town	State	
e 6 ma ector, p		1 M Burlel 2 Cremetion 3 Removal from State Completer, cremetory or other piecel														
after death. Page 6 y the funeral directe moval.		Onnetion 5 Other (Specify) SS.Peter & Paul Cem. 4/18/95 Cumberland, MD														
AL IIN death. Pag tuneral di examiner		22. NAME AND ADDRESS OF FACILITY George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502														
Er de the transfer de transfer		22 PART I Solar the diseases of sample that have that sound the death of the														
hours after d in by the or removal		23. PART I. Entar the di	sesses, or c	omplications the	t caused the de	ath. Do r	not anter t	ha mo	da of dyl	ng, such	as car	diac or respir	atory arre	at,	Approximate	
		Interval Between Onset and Destrict Cause (Fine)														
		disesse or condition	-	MY	ACARA	101	In	FA	RCT	MOI					IWIC.	
ted within completely ial, cremati event, t		DUE TO (OR AS A CONSEQUENCE OF):														
executed with and complete to burial, cremmatic even	-	Sequentially list conditions - CHRONIC ATRIAL FIBRILLATION 5415.													SUCC	
e be execute sician and conjust to burist traumatic	<u>o</u>	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												0413.		
ficate be physician ne prior t	CERTIFICATION	cause. Enter UNDERLYING														
certificate ding physiene pri	Ē	CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):														
F Hading	F	resulting in death) LAST														
the death the atten d Mental i	8															
at the deal by the att and Menta y Injury,	AL.	PART ii. Other significes	nt condition:	contributing to	deeth but not re	sulting	in the und	lerlying	ceuse g	lven in I	Part i.	24s. WAS AN /			ERE AUTOPSY FINDINGS	
that that and any	DICAL										_	1 TYES 2		C	MILABLE PRIOR TO OMPLETION OF CAUSE	
luires that signed Health a amy	# 1	2													F DEATH?	
w req been or, of	-	DID TOBACCO US	SE CONTR	IBUTE TO CA	USE OF DEAT	TH YE	SΠN	d ol	L UNC	ERTAIN						
he law r has be e Dept.	IAN:	25. WAS CASE REFERRED TO					TH (Check or									
ATTENDING PHYSICIAN: The law requires that ECOR. After this certificate has been signed by a faire death with the State Dept. of Health an 128 is marked, or Item 23 shows any	SICI	EXAMINER?		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 D Bar	aldana. I						
SICIA certification	РНҮ	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TiM		28c. INJ		sidence (SCRIBE HOW IN	LIURY OCCU	IRED.		
NG PHYS fter this eath with			Pending	(Month, D	Pay, Year)	INJ	URY	WO	RK? 'ES 2 🗌	NO I	200.00	yourse now in	0000	HED		
After death	В	3 Suleide	nvestigation	28a, PLACE O	F INJURY — At hor	ne ferm s	ttreet fector			, 110	28/ 1/0/	ATION (Circle)	and Advantage as	015		
TTEND TOR: 4 after d		_ , _ ,	Could not be letermined	building,	etc. (Specify)	, railrit, a	Miser, Inctor	y, onica			City	ATION (Street ar or Town, State)	na Number oi	r Hurai Hou	te Number,	
OR ATTENDING P OIRECTOR: After the hours after death	COMPLETE	29a. CERTIFIER		1												
Z Z Z Z Z	린	(Check only 1 M CERTI			my knowledge, das											
	ō I	MEDIC	CAL EXAMINER	R: On the basis of a	xamination and/or in	vestigstio	n, in my opi	inion, de	eath occure	ed at the t	ime, date	and place, and	dua to the	cause(s) a	nd manner as stated.	
THE HOSPI THE FUNEF filed within PORTANT:	BE (296. SIGNATURE AND POTAL	OF CERTIFIER	10					29c. LICE	NSE NUM	BER		29d. DATE	SIGNED (M	onth, Day, Year)	
TO THE TO THE be filed		X	-	-					DZ	96.	57		► 4/	14/90		
	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH (ITEM	27) (Type.	Print)						,	113		
15	ı			s Judge				ince	Fre	deri	ck,	MD 20	678			
19		31. DATE FILED (Month, Day,)	fear)	32. REGISTRA	R'S SIGNATURE	_										
				Illia	R'S SIGNATURE	6										
L		1151 1 3	12/2(0)													

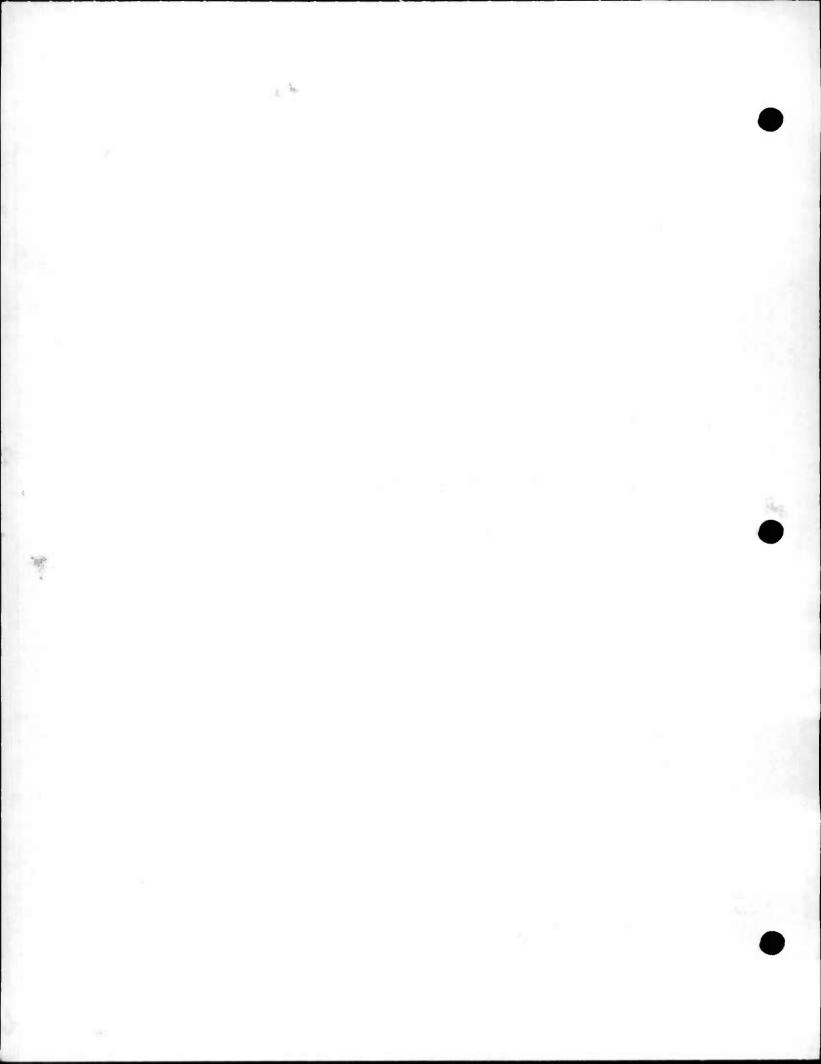


			HEGISTHAN		CERTIF	ICATE OF DEA	AIH	REG. NO.						
	١		1. DECEDENT'S NAME (First, Middle, Last)	D			MON		YEAR 3. TIME OF DEATH					
			FRANCIS 4. SOCIAL SECURITY NUMBER	B. Is. sex & A. AGE		RVEY		RIL 17, 19						
	10		214-07-3186		(In yrs. last birthday) 79 YRS.	MONTHS DAYS HOURS	MIN. Sep	e of birth t. 28, 1915	B. BIRTHPLACE (State or Foreign Country) Maryland					
	shoul	_	9a. FACILITY NAME (If not institution, give	The state of the s		9b. CITY, TOWN OR LOCA			UNTY OF DEATH					
	1. 2, 3 should	DIRECTOR	SACRED HEART	HOSPITAL		CUMBERLA	ND	А	LLEGANY					
	saßes	HE(10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
	permit. Pages			LEGANY	C	UMBERLAND			1 TES 2 NO					
	Sit	FUNERAL	12708 N. CRES	AP STREET		101. ZIP CO		7	S.A.					
02	ysicia rial-tr	2	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 X YES	IN U.S. ARMED	13. WAS DECENDENT	F OF NISPANIC ORIGI	IN? (Specify Yea or No-	14. RACE — American Indian, Bleck, White, atc.					
5-0020	attending physician, se as the burial-transit	BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 TES 2 X N		Prican, atc.)	Specify: WHITE					
	Se aff	回	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give kind of	USUAL OCCUPATION work done during most of wor	rkina 16	Sb. KIND OF BUSINESS/IN						
	spital o	APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	SPINN	se retired.)		CELANESE FIBERS CORPORATION						
	इं द	E COMPL	17. FATNER'S NAME (First, Middle, Lest) MICHAEL SHAY H	IARVEY		СК								
MAR	5 should	10 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and Numb								
	2 C E	۲	WILLIAM F. HAR	VEY					BEACH, VA23454					
RE	P 8 3		20a. METHOD OF DISPOSITION 1 (XBurial 2 (Cremation 3 (Ram	acval from State	6. PLACE AND DATE	OF DISPOSITION (Name of	N PA	TE 20c. LOCATION -	- City or Town, Stata					
M			4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIFE	S S	UNSET M	EMORIAL PA	RK 4/26	CUMBI	ERLAND, MD					
ALT	e funerial.		Mend 9.	Lochunch		GEORGE - 202 GRE	UPCHURC ENE ST.	H FUNERAL,	HOME,P.A. AND,MD 21502					
2	d in by the or removal		23. PART i. Enter the diseases, or	complications that cause	d the daeth. Do	not enter the mode of d	lying, such as car	rdiec or respiratory e	rrest, Approximate					
POP	ry fille		iMMEDIATE CAUSE (Final disesse or condition resulting in death)	Elst only one cause on a	Heavy /2	when wit	In Desley	ratan trull	Intarval Batwean Onset and Death					
260	omplete omplete il, crem event,			DUE TO (OR AS	A CONSEQUENCE O	F):		1100	2					
687	and contract provided in the p	NO N	Sequentially list conditions,	b. DUE TO COR AS	Jem	snone.			/dss.					
ŏ	ician nor to	TA.	If any, leading to immediate cause. Enter UNDERLYING											
. 8	theat physical iene p	띮	CAUSE (Disesse or Injury thet initieted events	DUE TO ION AS	A CONSEQUENCE OF	Pi	2 arms		10 415.					
P.0	th cer lending	CERTIFICATION	resulting in death) LAST	· Whenkers	ion /	Andersale	edeun	`	10 605.					
DS,	the att Menta	- 1	PART ii. Other significant condition	as contributing to death	but not resulting	in the underlying cause	niven in Part I	24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS					
CORE	ed by	EDICAL	Chronic Do huch	Pulmour			given all tart t.	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
	sign Sign Healt		Coronary	Arken Ar	1			1 TYES 2 NO	OF DEATN?					
R	has been Dept. of 1	2 3	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH YE	S NO M UN	ICERTAIN		1 TYES 2 NO					
VITAL	icate has been State Dept, of item 23 sh	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA									
5	certificate the State	Si	1 TYES 2 NO	HOSPITAL: 1 inpetient 2 - ER/Out	petient 3 DOA	OTHER:	Rasidenca 8 🗆 Oth	er (Specify)						
4 OF	this with	У РНУ	27. MANNER OF DEATN 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, INJURY AT WORK? M 1 YES 2		SCRIBE NOW INJURY OF	CURED					
DIVISION	OR ALTENDING DIRECTOR; After hours after death Item 28 is man	D BY	3 Suicide 6 Could not be	28a. PLACE OF INJUR building, atc. (Spi	Y — At home, term, s	street, factory, office	281. LO	CATION (Street and Number	or Or Rural Route Number,					
VIS	ALTEN ECTOR: 5 after n 28 i	11	4 Homicide datarmined				City	y or Town, State)						
Q		4	29a. CERTIFIER (Check only	CIAN: To the best of my know	viedge, death occurre	ed at the time, data and place	ca, and dua to the ca	suse(a) and menner as sta	rted.					
	THE HOSPITAL THE FUNERAL filed within 72 i	COMP							he cause(a) and menner as stated.					
	TO THE HOSPIT TO THE FUNER Be filed within 7	w	296. SIGNATURE AND TITLE OF CERTIFIE	1			CENSE NUMBER	29d. DAT	TE SIGNED (Month, Day, Year)					
	E 5 3 ₹	9	1/1/1	up v	D FI	4CP 1	D13601	AP	RIL 17th 1995					
	_		30. NAME AND ADDRESS OF PERSON WN	O COMPLETED CAUSE OF DE	EATN (ITEM 27) (Type,	Print)	7.501.1	411 D.	Comberland					
	21		31. DATE FIRE PYSPONIAL Day, Yearland	32 AFOISTRAR'S SIGN	PIY	721	viones	walsy to	(Une ferland					
		- 11	ייולאריי לי"ד"ייטטדי	Value of the sale	10 0 TH . 11				/4					

10 yrs. 1648.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		REGISTRAN	od ready			CERTIF	TOATE	UF	DEAL	н		REG. NO.			
		1. DECEDENT'S NAME (First		NT 111	TAGENTUT	maon	TSON					OF DEATH	Y	YEAR	3. TIME OF DEATH
		JOHN 4. SOCIAL SECURITY NUMBER	VERNO			RTSON					Apr		. 19		3:55 PM
		217-30-1889		5. SEX		rs. last birthday) YRS.	IF UNDER	DAYS.	NOURS	24 HRS. MIN.	7. DATE (Month	of BIRTH 7, Day, Year) 27, 19		6. BIRTHI Country	PLACE (State or Foreign
pino		9a. FACILITY NAME (If not in			73	Tho.	0) 0/77/	*******			Sep	27, 19			MD
3 should	œ	516 WARREN							OR LOCATIO	ON OF DE	ATH			NTY OF DE	
1. 2,	СТОВ	RESIDENCE OF DEC		-											
	1 111 1	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY LIMITS?
nit. P	DIR	MD	Alle	gany		Cu	mber.	Land	E						1 X YES 2 NO
burial-transit permit. Pages	RAL	10s, STREET AND NUMBER							1. ZIP CODE			10g. CITIZEN OF			HAT COUNTRY?
transi	FUNE	516 Warrer	Stree						21502		USA			A	
urial	윤	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDENT FORCES? 1	YES 2	NO XINO	- 11	yes, sp	ecify Cubar	ı, Mexicar	n, Puerto F	I? (Specify Yea Rican, etc.)	or No-	14. RACE Black	American Indian, White, elc.
the	COMPLETED BY	3 Widowed 4 Divo	4 1 1 1 1 1 1 1 1 1 1 1	IF YES, GIVE W	AR OR DATE	S	1	☐ YES	2 (XNO	Specify.	:			Specifi	
use as			EDENT'S EDUC		16	16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INC								white	
TO to		Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5+)		(Give kind of life. Do NOT u	work done d se retired.)	during most of working							
ched		12				Truck	Driver				Trucking				
deta	8	17. FATHER'S NAME (First, M	liddle, Last)			18. MOTHER'S N					ME (First, A	Aiddle, Maiden S	Sumame)		
ld be	BE	Frank H		son		Myrtle King									
5 should notified	6	19a. INFORMANT'S NAME (7)	,,			19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code,							Code)		
be n		Connie Twi						_		et;	Cumb	erland			
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Health and Merial Hygiene prior to burial, cremation, or removal. We any injury, or other traumatic event, the medical examiner must be notified at once.			n 3 🗌 Remo	val from State	cemeter	y, crematory or c	ther place)				DATE			City or Tov	
direc		1 (Xsurie) 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1 (Xsurie) 2 Cremetion 3 Removal from State Cemetery, crematory or other place) Pleasant Grove Cemetery 1 (Xsurie) 2 Cumberland, MD 22. NAME AND ADDRESS OF FACILITY													
tuneral di examiner		Scarpelli Funeral Home													
the fr		23. PART I_Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or resolvatory errors.													
d in by the or remove medical		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
filled on. or		IMMEDIATE CAUSE (Fin		,		75	1	2	7						Interval Between Onset and Death
ompletely filly cremation.		disease or condition resulting in death) a. My conduct on the consequence of the consequ													12
af. cre	NO	1													100
sician and c infor to buris traumatic		Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):												10 years	
ician nor to	CATION	If any, leading to immediate cause. Enter UNDERLYING													
ing phys rgiene p															
Hygi or of	CERTIFI														
Aenta Uny,	. 11	DART II Other circline	nt namelial mar							Pos					
ed by the att th and Menta any injury,	MEDICAL	1 /			Jean Dut I	but not resulting in the underlying ceuse given in Par					Part I.	24a. WAS AN A PERFORM			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
signed Health WS as	ă	- #	ypen	than)							- L	1 YES 2	NO		OF DEATH?
of H		DID TOPACCO II	SE CONITE	IDLITE TO CAL	ICE OF F	SEATH VI	·	10 F	7 11116						1 TYES 2 NO
Dept Dept	A	DID TOBACCO U 25. WAS CASE REFERRED TO		IBUIE IU CAU	_	PLACE OF OEA		-	LONCI	EKIAIN	<u> </u>				
s certificate has been sith the State Dept. of High or item 23 show	SICIAN:	EXAMINER? Tel	eased	HOSPITAL:	- 12 141		OTHER	:					41	ml	
certific the	≟	27. MANNER OF DEATH		28a. DATE OF I	NJURY	28b. TIM			URY AT	-	_	(Specify) CRIBE HOW IN	JURY OCC	UREO	
# X X	۲ ک		Pending Investigation	(Month, Da	r, Year)	IN.	URY M	WO	YES 2		THE RES				
After death	D BY	3 Suitalda	Could not be	28e. PLACE OF	INJURY -	Al home, ferm,	streel, facto	ry, offic	0			ATION (Street or	nd Number	or Rural Ro	outs Number,
DIRECTOR: hours after item 28 i	=		determined	building, e	tc. (Specify)						City o	or Town, State)			
DIRE hours	P.E.	29a. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the best of n	ny knowledg	e, death occurr	ed at the tin	ne, date	and place.	end due t	the cau	se(s) and man	nor no etet	ad .	
THE FUNERAL I filed within 72 h	OMPL														and menner as stated.
E FUN	Ü	29b. SIGNATURE AND TITLE								NSE NUMI					Month, Day, Year)
TO THE FUNER be filed within 7 IMPORTANT:	ω	Len	n -	Sn.	MO				DE	25	32		> /	dil	18 1995
F = =	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OF OEATH	(ITEM 27) (Type	Print)		~	-				7-54	,10,1111
5		9/2 1	Am,	Cumber	land	Md	2	115	72)
		31. DATE FILEO (Month, Day,	9	32 ABGISTRAR	'S SIGNATU	PAH			-				_		
l		MFR 1	9 199) Juan	Nation C.	A STANDARD									



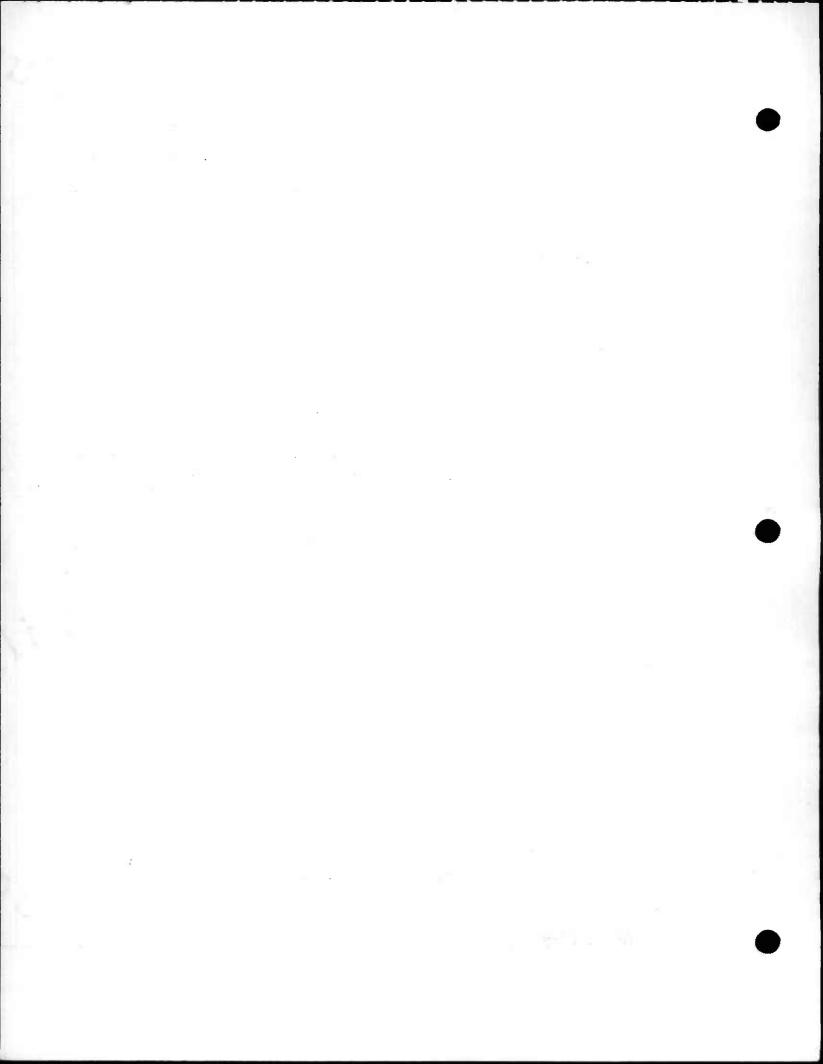
DIVISION OF VITAL RECORDS, P.O. BOX 68760

Casper E. Cline, 31. DATE FILED (Month, Day, Year)

STATE OF THE COURTS, F.O. BOX 00100, SPACE IMORE, MARTICAND 21213-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or remanal
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										95		354	5	
	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND /	DEPAR RTIF	TMENT 0	F HEALTH	AND I	MENTA	L HYGIEN					
1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF DEATH	AY	YEAR	3. TIME OF DE	EATH	
	Chloe	Viol	a	HAR	RIS		7	pri	ື 20, ້		TEAH	3:15	Р. м	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	MGE (In yrs. last	birthday)	IF UNDER 1 YE		R 24 HRS.	7 DATE	OF BIETH		8. BIRTH	PLACE (State or	Foreign	
0	212-24-7414	1 □ M 2 X F 9	0	YRS.	MONTHS DA	rs Hours	MIN. Z	pril	h, Day, Year)	1905	Country	Maryland		
	9a. FACILITY NAME (If not institution, give st	ireet and number)			9b. CITY, TO	VN OR LOCAT	ION OF DE	EATH		9c. COU	NTY OF DE	OF DEATH		
OR	Meridian Nursing	Home			Fre	deric	K			erick				
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CI	TV	
DIR	Maryland Fr	ederick				deric	k.				- 1	LIMITS?		
7	10e. STREET AND NUMBER					10f. ZIP COL				10g, CIT	IZEN OF W	HAT COUNTRY	A	
ER/	8951-A Indian Spr	ings Road				2:	1702					S.A.		
S	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARM	IED	13. WAS	DECENDENT	OF HISPAN	NIC ORIGIN	N? (Specify Ya	s or No-	14. RACE	— American In	ndlen.	
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 1 1 IF YES, GIVE WAR C	PR DATES	2 X NO If yes, specify Cuban, Maxican					Rican, atc.)			White, etc.		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) To FATHER'S NAME (First, Middle, List) 188. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) NUTSING 18. MOTHER'S NAME (First, Middle, List) 18. MOTHER'S NAME (First, Middle, List)														
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)														
MPI	/			Co	ok			I I	Nursin	g Hon	ne			
8	17. FATHER'S NAME (First, Middle, Last)					18, MOT			Middle, Meiden	Surname)				
BE	Charles Linton							Gilk						
2	19s. INFORMANT'S NAME (Type/Print) Betty H. Engle		19b. 8	MAILING 951–	ADDRESS (Str B Indi	an Sp	rings	Route Num.	ber, City or Tom Fre	n, State, Zij deric	ck, M	id. 217	02	
	20a. METHOD OF DISPOSITION 17 Burist 2 Cremation 3 Remo	oval from State	cemetery, crem	netory or o				DAT			City or Tov			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEF	leasan	t Hi	11 Con	etery	Apı	ril 1	24 19	95 I	rede	rick,	Md.	
	W. T. DI	2 Bal	1		Kee				d Fun	era1	Home	i		
	. were -	Sasgr		0021	106	East	Chun	rch S	St. F	rede	rick.	Md. 2	1701	
- 1	23. PART I. Enter the diseases, or cahock, or heart failure. I	omplications that can	used the dea	th. Do r	ot entar the	mode of dy	ing, suc	h as care	diac or rasp	iratory ar	rest,	Approxi	mata	
	IMMEDIATE CAUSE (Final	cial only one cause c	ni each inje.										Between nd Dasth	
	disesse or condition resulting in death)	. DV	AS A CONSECU	(~	-0-	1						14	2/2	
	,	DUE TO (OR	AS A CONSECU	UENCE OF	7:									
Z	Sequentially list conditions,		11	0 to	ie_							11	7	
Ĕ	if any, leading to immediate	DUE TO (OF	AS A CONSEQU	JENCE OF	7):									
2	cause. Enter UNDERLYING CAUSE (Disease or injury													
CERTIFICATION	that initiated eventa resulting in death) LAST	DUE TO (OR .	AS A CONSECU	JENCE OF	7:									
H		J												
_	PART II. Other significant condition	s contributing to dea	th but not re	sulting i	n the under	ying cause	given in	Part I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY	FINDINGS	
PHYSICIAN: MEDICAL	Athoras	clerati	7 1	Je.	to	2.6	ea	0	PERFOR			AVAILABLE PRIC		
입								1	1 TYES 2	- Military		OF DEATH?		
≥	DID TOBACCO USE CONTR	DIRLITE TO CAUSE	OF DEAT	H VE	s II NO	FIN	CEDTAIN					1 NES 2	NO	
₹	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CAOSI			H (Check only		LKIAII	101		_				
္က	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		o de la como	• 🗆 • • •						
Ě∥	27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. thJURY AT 28d. DESCRIBE HOW INJURY OCCURED													
	III VE NITURII 3 PRINDING													
à	2 Cultida	28a. PLACE OF INJ	URY — At hom	a, farm, s				28f. LOC	ATION (Street	and Numba	or Burni Br	oute Number		
	4 Homicide 8 Could not be	building, etc. (Specify)						or Town, State)					
	29a. CERTIFIER	CIAN: To the best of my k	nowledge 4:	lh oon	of set than at-	data and it	000	40.65						
COMPLETED	(Check only one) 2 MEDICAL EXAMINE											and means		
႘	29b. SIGNATURE AND TITLE OF PERPENSION	0/10			,, opinio	-			wire prace, at					
BE	STO. SHARKTONE AND TITLE OF EEGOFIER	118	, c	072	12	29c. LtC	ENSE NUM	MBER		29d, DAT	E SIGNED	(Month, Day, Yea	-	
2	20 NAME AND ADDRESS OF STREET	\Box	11	2	N. C.	D16	542 <u>8</u>				10	117)		
.	30. NAME AND ADDRESS OF PERSON WHO	OWMPLETED CAUSE OF	- DEATH (ITEM	27) (Type,	rrint)						1			

III, 300 West Ninth Street, Frederick, Maryland 21701



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THE PROPERTY OF ALLEMONING PRINCE	'HE FUNERAL DIRECTOR: After this certificate has been signs	filed within 72 hours after death with the State Dept. of Health and	, mel
INC	RAL	12 h	MMA
200	FUNE	withir	TANI
100	H C	filed	APORTANT: If Item 28 is marked

	FOR	STATE OF M	ADVIAND /	DEDART	MENT OF I	FAITH AND	MENTAL LIVOUR	-	
	1 - FOR STATE REGISTRAR RICHARD	RODNEY 1-	ANSELE	RTIFIC	CATE OF	DEATH	MENIAL HYGIEN REG. NO	lE .	
- §	1. DECEDENT'S NAME (First, Middle, Last) Richard Rodney						2. DATE OF DEATH DONTH D	1 19	3. TIME OF DEATH
		5. SEX 1 X M 2 F	6. AGE (In yrs. les		IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 15, 19	8.	BIRTHPLACE (State or Foreign Country) Cennsylvania
	Se. FACILITY NAME (If not institution, give street	et and number)		1	b. CITY, TOWN C	OR LOCATION OF D		9c. COUNTY	
TOR	335 West Main Str	eet			Thu	rmont		Fred	erick
DIRECTOR	100. STATE 100. COUNTY Virginia Fair	fax			town or Locat	TION		-	10d, INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER			, , ,		. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
EB	1852 Abbotsford D	rive				22182-3	301	U.	S.A.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [1F YES, GIVE WA	EVER IN U.S. AR YES 2X N R OR DATES	MED IO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexics 2 X NO Specifi	IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)		RACE — American Indian, Black, White, atc. Spec/ly: White
ED	15. DECEDENT'S EDUCAT	TION	16a. DE	CEDENT'S US	SUAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/INDUS	TRY
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	Visi	Do NOT use i	ıformati	-	U.S. Ge	eologi	cal Survey
	17. FATNER'S NAME (First, Middle, Lest) HOWard H.	• HANSI		70010	.1100		ME (First, Middle, Maiden	_	TNAG
BE	19a. INFORMANT'S NAME (Type/Print)	• 11/11/101		MAILING A	DORESS (Street a		Jane Route Number, City or Tow		IMMS
5	Lawrence J. Long		18	852 Ak	botsfo	rd Drive	, Vienna,	Va. 22	182-3301
	20a. METNOD OF DISPOSITION 1	ni from Stata	cometery, cre	MD DATE OF	place)	me of	OATE 20c. LO	CATION — City	or Town, State
1 3	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	OMIT OTH	sparg	22. NAME AN	ID ADDRESS OF FA	CILITY		
	Allan H	Ruby	M	00703	Keeney 106 Ea	y & Basfe ast Chur	ord P.A. F	uneral ederic	Home C, MD 21701
CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heert failure. List immediate CAUSE (Final disease or condition resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	ARTERI DUE TO (C	on each line	DUENCE OF):			CYLAR)		interval Batween Onset and Daath
ij	d								
: MEDICAL	PART ii. Other significant conditions of	contributing to d	eeth but not n	eculting in	the underlying	g ceuse given in	Part i. 24a. WAS AN PERFOF	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF OEATN (Ch	ack only one)		
2		IOSPITAL:	R/Outpatient 3		THER:		6 Other (Specify)		
ဟု				28b. TIME (OF 28c. INJI	JRY AT	28d. DESCRIBE NOW I	NJURY OCCUR	ED
HYS	27. MANNER OF CEATN	26a. OATE OF IN	JURY	404 44 45					
Y PHYSICIAN:	27. MANNER OF CEATN 1 SNetural 5 Pending	26a. OATE OF IN (Month, Day)	IJURY Year)	NJUR		ES 2 NO			
B	27. MANNER OF OEATN 1 S Pending	(Month, Day,	Year) NJURY — At hor	INJUR		ES 2 NO	281. LOCATION (Street a City or Town, State)	and Number or I	Ruraí Route Number,
BY	27. MANNER OF OEATN 1 S_Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 27. MANNER OF OEATN 5 Pending Investigation 6 Could not be determined	28s. PLACE OF building, at	Year) INJURY — At hor c. (Specify) y knowledge, dea	injur	M 1 7	ES 2 NO	City or Town, State) to the cause(s) end mer	nner es stated.	Rural Route Number,
BE COMPLETED BY	27. MANNER OF OEATN 1 S_Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 27. MANNER OF OEATN 5 Pending Investigation 6 Could not be determined	28s. PLACE OF building, at	Year) INJURY — At hor c. (Specify) y knowledge, dea	injur	M 1 7	ES 2 NO	City or Town, State) to the cause(s) end mer time, data and placa, an	oner ea stated. d due to the co	
E COMPLETED BY	27. MANNER OF OEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	(Month, Day, 28a. PLACE OF building, at AN: To the best of m On the basis of axai	Year) INJURY — At hose, (Specify) y knowledge, determination and/or in OF OEATN (ITEM DER	injuration, street occurred investigation,	at the time, data	and place, end due sath occured at the 29c. LICENSE NUR	City or Town, State) to the cause(s) end mer time, data and placa, an	d dua to the co	euse(a) and manner as stated. GNED (Month, Day, Year)

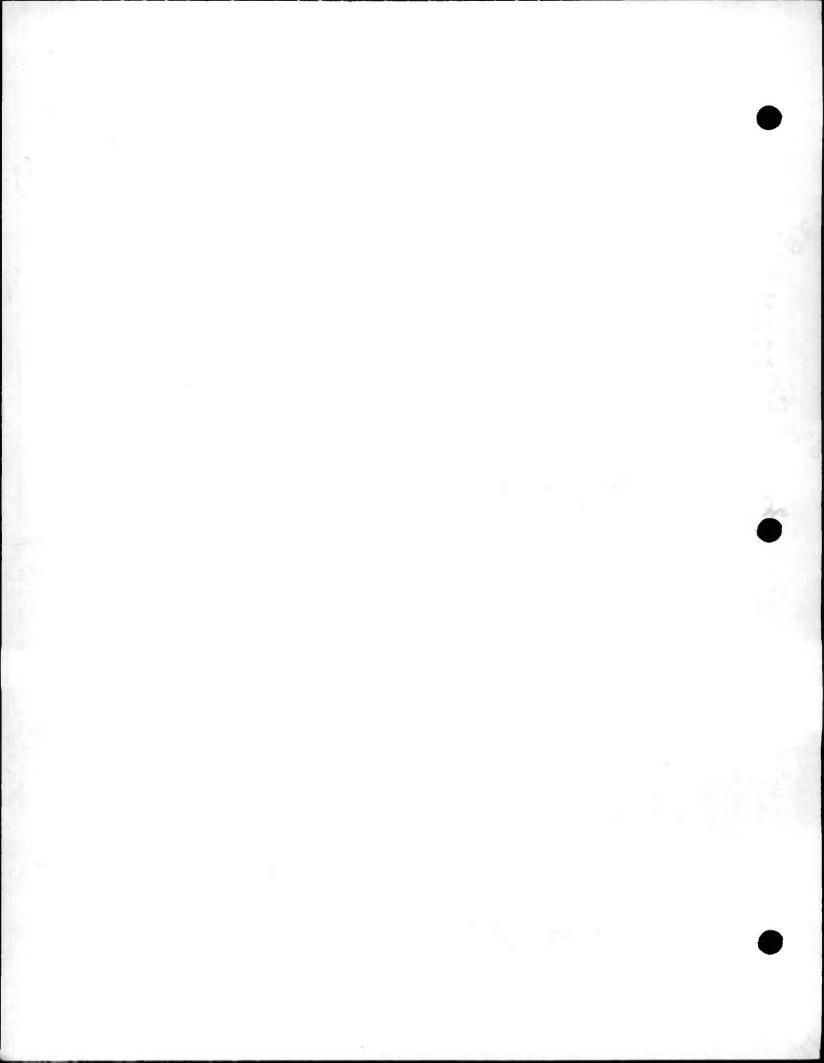
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			1 - FOR STATE REGISTRAR	STATE OF MARYL			F HEALTH AND OF DEATH	MENTAL HYGIE		
			1. DECEDENT'S NAME (First, Middle, Last) OS C.A.R. P.	tacco				2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH
					(In yrs. last birthdi	y) IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
Should			219 10 2488 9a. FACILITY NAME (If not institution, give atra		69 YRS		YS HOURS MIN.	May 18,	1925	Maryland
3 sho	- 1	Œ	Kimbrough Hospital				wn or location of the Meade	DEATH	9c. COUNTY	y of DEATH Ne Arundel
1, 2,		6	RESIDENCE OF DECEDENT			101	L Fledde		1 1	e Aruider
it. Pages		DIRECTOR	Maryland Anı	ne Arundel		Harmans	OCATION			10d. INSIDE CITY LIMITS? 1 ☐ YES 2XX NO
permit.	l	ĭ.	10e. STREET AND NUMBER				10f. ZIP CODE			N OF WHAT COUNTRY?
ian. transit		FUNERAL	18 Hanford Drive				21077			ed States
215-0020 attending physician. se as the bunal-transit		ĕ.	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 12 YES IF YES, GIVE WAR OR D 1943 —	2 NO	If ye	DECENDENT OF HISP/ a, specify Cuban, Maxic YES 2 NO Spec	ANIC ORIGIN? (Specify Y sen, Puerlo Ricen, etc.) lify:	'ss or No 14	I. RACE — American Indian, Black, White, etc. Specify: White
1215 r attend use as			15. DECEDENT'S EDUCA (Specify only highest grade of	TION ompleted)	16s. DECEDEN	I'S USUAL OCCU of work done durin	PATION a most of working	16b. KIND OF B	USINESS/INDUS	
d = p		E	Elamentary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	use retired.)		_		
the hospital detached fo	once.	COMP	17. FATHER'S NAME (First, Middle, Last)		Sale	sman	Les MOTUEDIO N	AME (First, Middle, Maide	rance C	ompany
YLA by the	at or	CC	Oscar P. Harry Sr.				Emma	AME (First, Middle, Maide Weber	,	
MARYLAND retained by the hospit should be detached	notified	8	19s. INFORMANT'S NAME (Type/Print)		19b. MAIL	NG ADDRESS (St		Route Number, City or To		ode)
be ret	be not	2	Mrs. Elisa L. Harı	- Y	18 1	lanford	Drive Har	mans, Mary	pland 2	1077
6 may	must b		20s. METHOD OF DISPOSITION 1-Si Burlel 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	raf from State cen	b. PLACE AND DA metery, crematory	r other place)			OCATION — City	
			21. SIGNATURE OF FUNERAL SERVICE LICE		TEACOWI.	22. NAN	E AND ADDRESS OF F	ACILITY		, Maryland
BALTI or death. P the funeral	examiner		Stanley 2	7. Locus	rer			ke Funeral umbia Pike		Inc ott City21043
of of	medical		23. PART i. Enter the discusses, or co ahock, or heert fellure. Li	mplications that cause	d the deeth. D	o not enter the	mode of dying, au	ch es cerdiec or res	piretory arree	t, Approximata
24 hours filled in t	the m		IMMEDIATE CAUSE (Final	4			N.1 () ·		interval Between Oneat and Death
within within a	event, t		disease or condition resulting in death)	DUE TO (OR AS			Arten 1	sease		5 years
executed and com		Z	Sequentielly list conditions, b.	Hyper	tensio	N				>30yers
clan be	traumatic	CATION	if any, leading to immediate cause. Enter UNDERLYING	Chronic			monon Di	scase - Se	414	730yers 10years
certificate ding phys	other	RTIFI	CAUSE (Disease or injury that initieted eventa resulting in deeth) LAST	DUE TO (OR AS A						
eath aften	njury, or	병	d.							
	= =	Ä	PART II. Other eignificent conditions	contributing to deeth b	out not reauitir	g in the under	lying ceuse given in	Part I. 24a. WAS A	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
3 E B	s any	MEDICAL						1 🗆 YES	2 NO	COMPLETION OF CAUSE OF DEATH?
~ e e	show		DID TOPACCO LISE CONTRI	DUTE TO CALICE C	DE DEATH	VEC 12 NO	- INICEPTAL			1 TES 2 NO
	n 23	AN	DID TOBACCO USE CONTRI	BUTE TO CAUSE C		EATH (Check only		ІМ Ц Т		
F VII.	r item	Sic	EXAMINER?	HOSPITAL:	patient 3 DO/	OTHER:	Homa 5 🗆 Rasidencs	8 Other (Specify)		
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his	marked, or	PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b.	IME OF 280	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUP	ŧΕD
TENDING OR: After	5 60	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY building, stc. (Spec	Y — At home, fari		YES 2 NO	281. LOCATION (Street	t and Number or	Rural Route Number,
OR ATTEN	00	ETED	4 Homicide datarmined					City or Town, State		
= = = = = =	ANT: If ite	COMPLET		AN: To the best of my know On the basis of examinatio						suse(s) and manner as stated.
TO THE HOSPIT	MPORT	B	29b. SIGNATURE AND TITLE OF CERTIFIER	ann Rubart C	of Mc		29c. LICENSE NU		29d. DATE S	IGNED (Month, Day, Year)
FF.	0 =	임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (7					71.3
1	51		ROBERT WOLFGANG, 31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE.	KIMBROU	GH ARMY HO	OSPITAL, F	r. MEAD	DE, MD 20755
			APR 2 8 1995	Jaha d'aviles	or Randall					

FOR 1 STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CE	RTIFIC	ATE O	F DEATH	F	REG. NO.			
		1. DECEOENT'S NAME (First, Middle, Last)						2. DATE OF			3. TIME OF	DEATN
		Arshad Imam						Apri	11 21	, 1995	3:0	0 PM
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. lest	birthday) IF t	INDER 1 YEAR	F UNDER 24 HRS.	7 DATE OF	DIOTH			
		None	1 🔽 M 2 🗆 F	55	YRS. MON	THS DAY	HOURS MIN.	Sep 3	1 0	30 Cour	India	3
pino		90. FACILITY NAME (If not institution, give s	street and number)			CITY TOW	N OR LOCATION OF D		, 19	0- 00mm or	THUL	1
3 should	œ l	Frederick Memori	C. C. CLORES	1			ederick	EAIN		9c. COUNTY OF		
. 2,	일	RESIDENCE OF DECEDENT	ar nospital	L		LTG	edelick			rred	erick	
sac	<u> </u>	10s. STATE 10b. COUNT	Y		10c. CITY, TO	WN OR LO	CATION				10d. INSIDE	CITY
a.	DIRECTOR	Pakistan			Kar	achi					LIMITS	37
ji.		10e. STREET AND NUMBER					10f. ZIP CODE		T	10g. CITIZEN OF	1 YES	
St.	8	R-288 Metroville	III Gulet	19 n -0-	i ahal					Paki		HTT
020 physician. burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE			40 1110 0	None					
21215-0020 al or attending physici for use as the burial		1 Never Married 2 Merried	FORCES? 1 Y	ES 2 X NO		II yes,	ECENDENT OF NISPA specify Cuben, Mexic	en, Puerto Rica	ipecify Yes o n, etc.)	r No— 14. RAC Bla	CE — America ck, White, etc.	ı Indlen,
15-0C tending p as the t	BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OF	R DATES		1 🗌 Y	ES 2 X NO Speci	ly:			istani	on
15 trend trend	0.	15. DECEDENT'S EDU	CATION	16a, DEC	EDENT'S USU	AL OCCUPA	TION	16h KII	UD OF BURN	NESS/INDUSTRY	ISLAIII	all
2121 cal or atte	E	(Specify only highest grade Elementary/Secondary (0-12)		(Give	e kind of work of Oo NOT use reti	done during	most of working	IOU. KII	VD OF BUSIN	VESS/INDUSTRY		
ed for the	7	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	R.	anking	Off	ioor	117.	hih I	Dowle T	L .1	
AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran	COMPLETED	17. FATHER'S NAME (First, Middle, Last)			пкшв	OII				Bank, L	ca	
YL/		Mohammed		TMAN			18. MOTNER'S N					
Bed b	BE	190. INFORMANT'S NAME (Type/Print)		IMAM				- Un -				
MARYLAND retained by the hospite 5 should be detached notified at once.	2	Azra Imam					et end Number or Rural					
					200 Me	etrov	ille III,	BTCK	I, Ka	rachi,	Pakist	an
Fector, pa		20e. METHOD OF OISPOSITION 1 X Burlal 2 ☐ Cremetion 3 X Rem	oval from State	20b. PLACE AN	DO DATE OF DIS	POSITION	(Name of	OATE	20c. LOCA	ATION — City or 1	lown, State	
Nects Breeze		4 Donation 5 Other (Specify)	2/2/24/2	0ak1av	vn Mem	Park	Apr 23	1995	Prin	nceton,	New J	ersev
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		21. SIGNATURE OF FUNERAL SERVICE LIC	TEMBER //	4		22. NAME	ANO ADDRESS OF FA	CILITY				
AL death fune	- 1	Ketthhung	- Pohenou	√M0070	0		ney & Basi					
B B after removal dical	\neg	23. PART I. Enter the diseases, or o				106 1	East Churc	ch St.	Frede	erick.		
S = 2		shock, or heart fallure.	List only one cause or	n each line.	in. Do not e	nter the r	node or dying, aud	n aa cerdiec	or respire	tory arrest,		oximete /al Between
	- 1	IMMEDIATE CAUSE (Final disease or condition										t and Death
1 a fe a		resulting in death)	DUE TO (OR A DUE TO (OR A DUE TO (OR A	ae 1	3che	ui 9	,				2	2 week
			DUE TO (OR A	S A CONSEQU	JENCE OF):		-1 0					Louks
687 ecuted ind con burial,	Z	Sequentially list conditions,	· 5457	emic	- 0	240	lida				9	Coseks
BOX 68 sate be execut hysician and c prior traumatic	CERTIFICATION	If any, leading to immediate	DUEND (OR A	S A CONSEQU	IENCE OF):							
	2	CAUSE (Disease or Injury	c (YILLA)	home	9							
P.O. B(th certificate tending physi if Hygiene pri or other ti	E II	that initieted events resulting in death) LAST	OLIE TO (OIL A	S A CONSEOU	ENCE OF):							
o Hand	E	resoluting in deathly EAST	d									
ORDS, F s that the death ned by the atte tth and Mertal any injury, ra		PART II. Other algnificant condition	s contributing to deat	h but not rea	witing in th	e underly	ing cause gluen in	Bort I Od	. WAS AN AL	ITTORON .		
RE the sand and sand in in	EDICAL								PERFORM		b. WERE AUTOR AVAILABLE P	RIOR TO
ECOR uires that signed by Health and	ā	liver Failure	renat ta	rune	17013	rron	Chest I was	18	YES 2] NO	OF DEATH?	OF CAUSE
	Σ	DIECTOR I PULL	mouning To	allen	2 1 1/2	4 re	rkalowy	9			1 TYES 2	NO
	PHYSICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATI	H YES E	ON [UNCERTAI	N				
VITAL JAN: The law rifficate has I te State Dept or Item 23	3 1	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEATH (C)		e)					
F VIT, SICIAN: Th certificate I the State	S	1 TES 2 NO	1 inpetient 2 - ER/O	outpatient 3		HER: Nursing H	ome 5 - Residencs	6 Other (Sp	ecify)			
OF PHYSIC this cer with th	Ŧ	27. MANNER OF DEATN	28e. DATE OF INJUR (Month, Day, Yee	tY	28b. TIME OF	28c. I	NJURY AT WORK?	28d. DESCRI	BE NOW INJ	URY OCCURED		
NG PHYSI NG PHYSI tter this c eath with marked,	BY	1 Natural 5 Pending 2 Accident Investigation	(110.11.1, 0.0), 100,	'	MOON		YES 2 NO					- 1
ON VDING I After death		3 Suicide 8 Could not be	28e. PLACE OF INJU	JRY — A1 home	e, ferm, street,	factory, of	fice	261. LOCATIO	N (Street end	d Number or Rural	Route Number,	
DIVISION OF VITA DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State C	E	4 Nomicide determined	building, atc. (S	респу)				City or To	wn, State)			
DIV DIREC	9	294. CERTIFIER	CIAN TO ALL A A									
로 보 전 🛎	COMPLETED		CIAN: To the best of my kn									
HOSPITAL FUNERAL within 72	8		R: On the basis of examina	mon end/or inv	estigation, in	my opinion	, weath occured at the	time, date end	place, end o	Jue to the couse(a) end manner	es stated.
THE HOSPI THE FUNER filed within	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	6	2 `			29c. LICENSE NUI	MBER	2	29d. DATE SIGNE) (Month, Day,	Year)
0 0 9 W	ğ	mehaer	- of which	en 1	ND		1046	120		× 4-	21-	45
		30. NAME AND ADDRESS OF PERSON WHO		DEATH (ITEM	27) (Type, Print)		71	- 4				
i		MICHAEL COPI	zesti, 1	UD,	5016	07	74 ST, 1	Frede	nick	Ma	2170	/. ·
		31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SI		-	-	-				-	
		APP 2 8 199	Julia da	value R	1.18							



he hospital	detached fo	once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, crenation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
nay be re	page 5	it be no	
Page 6 n	director	ier mus	
death.	e funeral	examir	
ours after	In by th	nedical	
hin 24 hi	tety filled mation.	t, the r	
uted wit	1 comple	lc even	
e be exec	sician and	traumat	
certificat	ding phy	other	
ne death	the atten Mental H	ıjury, o	
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w require	pt. of He	3 show	
N: The la	icate has State De	Item 2	
HYSICIA	his certif with the	ked, or	
NDING P	R: After t	is mar	
OR ATT	DIRECTO hours aft	Item 28	
OSPITAL	UNERAL Ithin 72 I	ANT: IL	
TO THE H	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPORT	

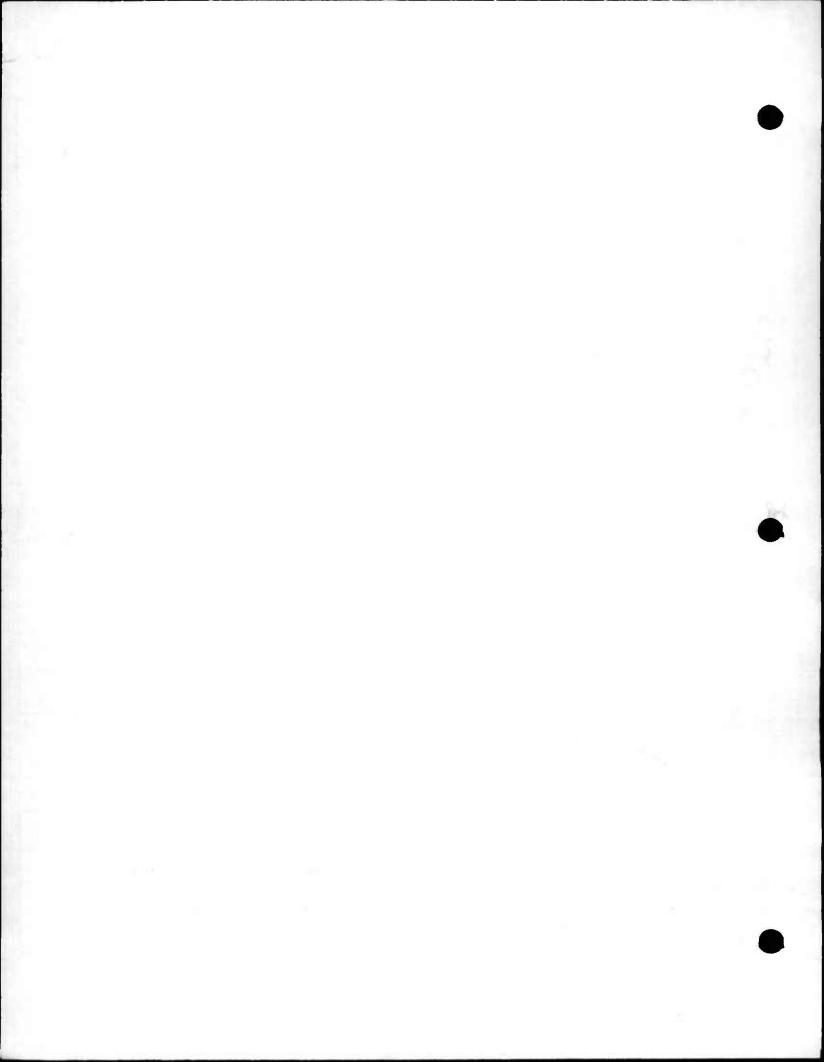
90								95	13549
	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMEN	IT OF H	IEALTH AN	D MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)		CENTI	FICAI	E UF	DEATH	REG. NO		3. TIME OF DEATH
	Robert Jone	25					MONTH 2	2 95	1 2056 "
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday	IF UND	ER 1 YEAR	IF UNDER 24 HR	40.6. M. C. M. I		ATHPLACE (State or Foreign untry)
	248.14.2353	1 M 2 🗆 F	16 YRS.	MONTHS	DAYS	HOURS MIN	JUNE 4 191		OUTH CANROLIN
00	Sa. FACILITY NAME (If not institution, give					OR LOCATION OF	F DEATH	9c. COUNTY OF	
DIRECTOR	ANNE ARUNDEL MED	ICAL CENTER		I P	NNAP	OLIS		ANNE	ARUNDEL
<u>ب</u>	10e. STATE 10b. COUNT	Y	10c. C	TY, TOWN	OR LOCAT	TION			10d. INSIDE CITY
		ARUNDEL	AN	INAPO	LIS				1 TYES 2 NO
FUNERAL	10e. STREET AND NUMBER					. ZIP CODE			F WHAT COUNTRY?
Ü	701 GLENWOOD ST.					21401			USA
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR O	N U.S. ARMED 2-1-10 PATES	13	If yes, sp	ecify Cuban, Ma: 2 X NO Sp	PANIC ORIGIN? (Specify Yexicen, Puerto Ricen, etc.) ecify:	Sz	ACE — American Indian, lack, White, atc. pecify: BLACK
	15. DECEDENT'S EDU	JCATION	16a. DECEDENT	S USUAL	OCCUPATIO	ON	16h KIND OF BU	SINESS/INDUSTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 8th	completed) College (1-4 or 5+)	(Give kind o life. Do NOT LABORI	f work don use retired.	e during mo	st of working	U.S. NAV		
OM	17. FATHER'S NAME (First, Middle, Lest)					18 MOTHER'S	NAME (First, Middle, Maiden	Sumama)	
BE C	RALEIGH JONES			_		ROSA	ANNA	,	
10	198. INFORMANT'S NAME (Type/Print) KATHERINE BARLOW		3405	W. I	ss (Street e FORES	nd Number or Ru T PARK	AVE. BALTIM	m, State, Zip Code) IORE, MD	. 21216
	20a. METHOO OF DISPOSITION 1		o. PLACE AND DATE netery, crematory or			ame of	4/28/195 20c LO ANN	CATION — City or	Town, State MD •
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22	. NAME AN	D ADDRESS OF	FACILITY	- 1	
	Larry D. R.	else		8	321 W	EST ST.	MORTUARY, ANNAPOLIS,	MD. 21	401
	23. PART i. Entar the diseases, of ahock, or heart feliure.	complications that caused List only one ceuse on e	d the death. Do	not anta	ar the mo	da of dying, a	such as cerdiac or reap	iratory arrest,	Approximata Interval Between
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)	Ventris	e Ona	File	rillo	tin	Arrest		Onaet and Death
	rounting in deathy	DUE TO (OR AS A	CONSEQUENCE	6 7):	/	0	, , , , , ,	~/	(
Z	Sequentially list conditions,	. Cardiow	GORATI	ry	/ (Card	io Cente.	- hext	
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	PUE TO (OR AS A	CONSEQUENCE	The second	4. 2		0	(
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE	OF):	INO.	حريد			
E	resulting in death) LAST	d	0						į
5	PART ii Other significant condition		s. 271 se mas						
S	PART II. Other algoliticant condition	is contributing to death b	out not resulting	in the t	indarlying	g ceuse given	in Part i. 24a, WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICA							1 _ YES 2	NO	COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONT	PIRLITE TO CALISE O	E DEATH V	ES 🖂	NO C	UNCERTA	AINI 🗖		1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE			UNCEKIA			
SIC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outp	patient 3 DOA	OTHE 4 No		e 5 🗆 Resident	ce 8 Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. Til		28c. INJI	URY AT	28d. DESCRIBE HOW I	NJURY OCCUREO	
BY	1 Natural 5 Pending 2 Accident Investigation			M		ES 2 NO			
ETED I	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, to	ctory, office		281, LOCATION (Street a City or Town, State)	and Number or Rura	el Route Number,
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	ICIAN: To the best of my knowl	ledge, death occur	red at the	time, det-	and place and	fue to the cause(s) and	Ther so stated	
COMPL		R: On the basis of examination							e(a) and manner as stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIE	Adll	15.1			29c. LICENSE N	NUMBER		ED (Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	WD.	. 0.		MX.	D41216	▶4-27	2-75

SON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

HG | M. D. 1204

1995 32! REGISTRAN'S SIGNATURE

JULY WILLIAM CONTROLL



AMENDED #22 #10e 4/12/95 ELM PG County

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	OIAIL OI IIII	CE	ERTIF	ICATE	OF DEATH	IN MICH	REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)						2. 0	DATE OF DEATH			3. TIME OF DEATH
	HELEN LO	UISE JACK	SON					APR 7 1	995	YEAR	4:54 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 8	B. AGE (In yrs. las	l birthday)	IF UNDER 1 Y			MATE OF BIRTH Month, Day, Year)		8. BIRTH	PLACE (State or Foreign
	135-20-9845	1 🗌 M 2 💢 F	65	YRS.	MONTHS D	AYS HOURS MI		$19^{7}, 19^{2}$	29	PENN	" SYLVANIA
	9e. FACILITY NAME (If not institution, give st	reet end number)			96. CITY, TO	WN OR LOCATION O		, , , , , , , , , , , , , , , , , , , ,		NTY OF D	
DIRECTOR	NATIONAL NAVAL	MEDICAL C	ENTER		1	BETHESDA				MONT	GOMERY
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY			100 017	Y, TOWN OR I					PILITY	
Ë						OCATION					10d. INSIDE CITY LIMITS?
		KT		טע	NKIRK	10f. ZIP COOE			40- 017	17511 05 11	1 X YES 2 NO
¥.	104. STREET AND NUMBER	Uncle Cha	rlie Sp	our		20754					
FUNERAL	11, MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS	DECENDENT OF HI	SPANIC OF	RIGIN? /Specify Yes			STATES
	1 Never Married 2 Merried	FORCES? 1 [YES 2 X	10	It ye	s, specify Cuben, Me YES 2X NO S	exicen, Pu	erto Ricen, etc.)		Black	— American Indian, , White, etc.
βÁ	3 Widowed 4 Divorced					120 24 110 0	poony.			BLA	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade)	ATION completed)	(Gi	ve kind of	USUAL OCCL	PATION ag most of working		16b. KIND OF BUS	SINESS/INC	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life.	Do NOT u	se retired.)		i				
MP	12		PR	OCUR.	EMENT	ANALYST		U.S.		ERCE	DEPT.
	17. FATHER'S NAME (First, Middle, Last) MATTHEW J. WINCH	IECTED						irst, Middle, Maiden	Sumeme)		
BE	19e. INFORMANT'S NAME (Type/Print)	IESTEK	-					100RE			
2	GRAHAM L. JACKSON	r				reet and Number or R				,	
	200. METHOD OF DISPOSITION					CHARLIE					
	1 N Burtal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	rvel from State	cemetery cre	matory or o	of disposition ther place CEME	TEDX	1		CATION —		
	21. SIGNATURE OF JUNERAL SERVICE LICE	ENDRE)	OLDAK	11771							ARYLAND
	> (11/1.6)	Alone It	2	M859	AL	EXANDER S	S. PC	PE FUNE	Ries F	HOMES	
	may x	10/61			55	38 MARLBO	DRO P	TKE, FOI	RESTU	TILE	MD 20747
	23. PART I. Enter the diseases, or canada ahock, or heart failure. L	Dmpfications\that of list only one cause	caused tha de e on aach line	ath, Do i	not enter the	mode of dying,	such as	cardiac or respi	ratory an	reat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition										Onset and Death
ŀ		METAS	STATIC OR AS A CONSEC	SMAL	L CELL	LUNG CA	NCER				1 year
_		DOE 10 (0	H AS A CONSEC	JUENCE O	r);						
o I	Sequantially list conditions,		R AS A CONSEC	DUENCE O	n:						
¥	if any, leading to immediate cause. Enter UNDERLYING				-						j
Ĕ	CAUSE (Disessa Dr injury that initiated events	DUE TO (O	R AS A CONSEC	UENCE O	F):						
토	resulting in death) LAST	ū									
EDICAL CERTIFICATION	DADT II. Other electricant conditions										
8	PART II. Other algorificant conditions	Contributing to de	aath but not r	aauiting	in the unda	iying cauaa giver	n in Part	i. 24e. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă								1 🗆 YES 2	MNO		CDMPLETION OF CAUSE DF DEATH?
ž											1 TES 2 NO
PHYSICIAN: MI	DID TOBACCO USE CONTR	IBUTE TO CAU					IAIN []			
힐	EXAMINER?	HOSPITAL:			OTHER:						
¥ I	27. MANNER OF DEATH	1 X Inpatient 2 E		28b, TIM		Home 5 Resider	_				
	1 X Natural 5 Pending	(Month, Day,	Year)		URY	WORK?		DESCRIBE HOW II	NJURY OC	CURED	
à	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF I	INJURY — At hor	ne, farm,			_	LOCATION (Street a	and Number	or Burn! B	outs Number
COMPLETED	4 Homicide 8 Could not be determined	building, etc	c. (Specify)		, , , , , , , , , ,			City or Town, State)	ina manasi	Dr Morer /	oute reamon,
9	29e. CERTIFIER										
鱼	(Check only one) 2 MEDICAL EXAMINER										
	2 MEDICAL EXAMINER			vesirymic	., н. нту орил			usia end piece, en			
BE	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE	NUMBER			. /	(Month, Day, Year)
၉	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIFE		1 070 /Y.:	Colored	D-43				1 /c	7/95
* 1	THE NAME OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEN	27) (Type	rnnt)	NATTON	IAL N	AVAL MEI	TCAT.	CEN	TED
									- 1 0111	OLL	ICK
	T S KNRE LCDR	MC USNR	S EIGNATUDE					D 20889-			IEK

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filter death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

0/10

hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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APR 12 1995

DHMH-16 Rev 1/89

rurs after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 TO THE HOSTIN. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 PA TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled be filed within 72 hours after death with the State Dept. of Health and Mantal Narran and Completely filled. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

detac		once
20		10
Should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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31. DATE FILED (Month, Day, Year)

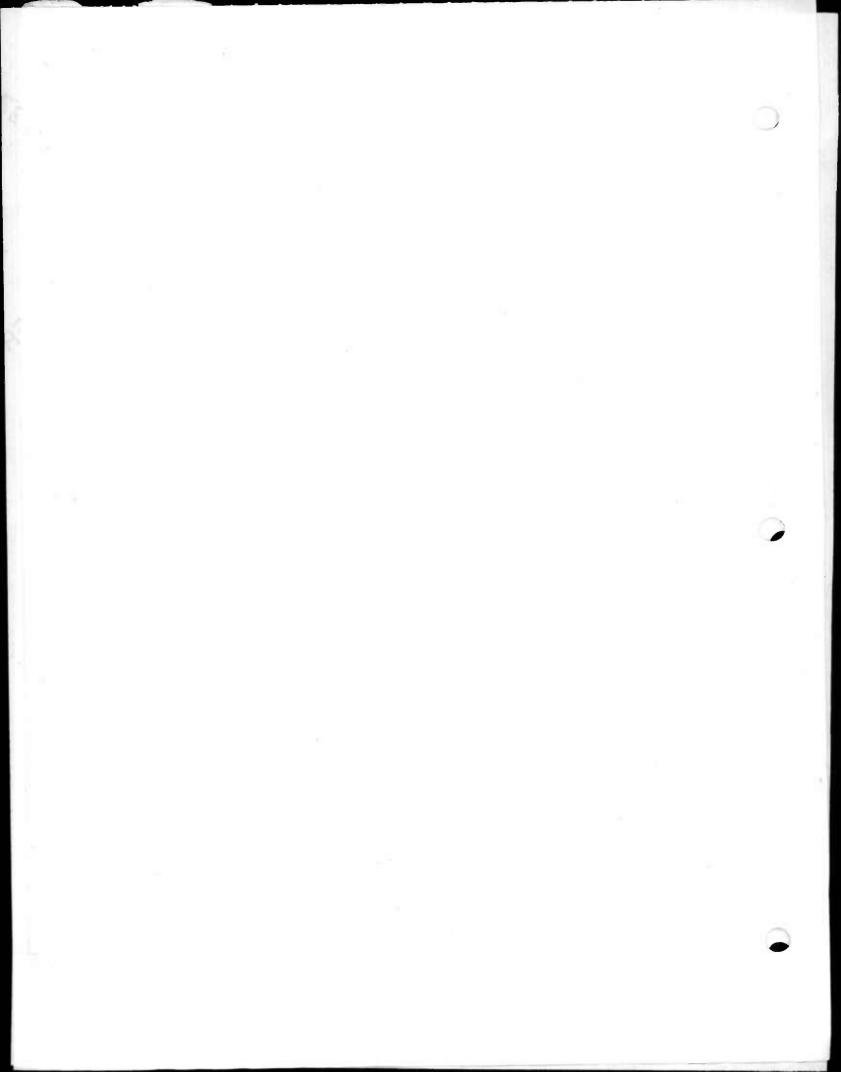
32. REGISTRAR'S SIGNATURE

	FOR 1 - STATE	STATE OF MARY							MENTAL HYGIEN	IE .	J	13331
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	Julia		EN		V S,	DEAT	ГН	PEG. NO 2. DATE OF DEATH MONTH D C 4		EAR :	3. TIME OF DEATH LISP M
	4. SOCIAL SECURITY NUMBER 579-42-1489		E (In yrs. lea	VRS.	IF UNDE	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 7/29/05	0.	BIRTHP! Country)	LACE (State or Foreign
OR O	9e. FACILITY NAME (If not inetitution, give a Pineview Nursin		view	Mano		Y, TOWN O		ON OF DE	ATH	9c. COUNT	OF DE	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT			10c. CIT	Y, TOWN	OR LOCATI						10d. INSIDE CITY LIMITS?
	DC	N/A		2/	Was	shing					1	YES 2 NO
RA	100. STREET AND NUMBER 419 Madiso	n St NU					2001					IAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	8 2 XN			WAS DECE	ENDENT C	OF HISPAN	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)			- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	16a. OE (Gi	CEDENT'S ive kind of Do NOT us	USUAL Owork done	CCUPATIO during mos	N Il of worldr	ng	16b. KIND OF BU	SINESS/INDUS		
M M	12 Yrs	None	Tea	cher	's A	lide/	Dome	stic				
	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NAI	ME (First, Middle, Malden	Surname)		
8	Ben Jone	S	1000						L. Sheff:			
2	Benjamin T. Jenk	ins	198						DC 20019		ode)	
	20a. METHOD OF DISPOSITION 1 Togenial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	ob. PLACE A	matory or o	of bispos ther place) Memo	sition/Nar	™ool Par	k 4/	0ATE 20c. LO 15/95 Lat	cation - cit	y or Town	n, State
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE CONTRACTOR	•	_		NAME AN		Joh		es Co.	, In	
3	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition rasulting in death)	List only one cause on	each Ilna	Pu	One	or the mod	da of dyl	Ing, such	as cardiac or respi	iratory arrea	t,	Approximete Interval Between Draset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	BUE TO OR AS	ASONSES LAI	DUENCE OF	Bilo	of w	Un	les	ent- Ayon	tah		248az
	PART II. Other algnificant condition	a contributing to death	but not re	esulting	in the u	nderlying	ceuse ç	iven in i				VERE AUTOPSY FINDINGS
I: MEDICAL									PERFOR		0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH? YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?						ACE OF O	EATH (Che	ck only one)			
YSI	1 TES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Ou	rtpetient 3	□ DOA	4 Nur		5 🗆 Re	sidence i	B Other (Specify)			
ву Рн	27. MANNER OF DEATH 1 A Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		28b. TIM INJ	E OF URY M	28c. INJU WOR 1 Y	RY AT	NO	28d. DESCRIBE HOW I	NJURY OCCUP	RED	
8	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUI building, etc. (Sc	RY — At horecify)	me, term, s	street, tec	tory, offica			28t. LOCATION (Street & City or Town, State)	and Number or	Rurel Aou	ite Number,
COMPLET		CIAN: To the best of my kno									ause(a) a	ind manner as stated.
TO BE C	10. NAME AND AGORESS OF PERSON WH	SIMI	A	Ula	rdi	10	290 LICE	NSE NUM	1535.	29d. DATE S	IGNEO A	Aonth, Pay, Year)

TAPPETERS JULBURY SALE

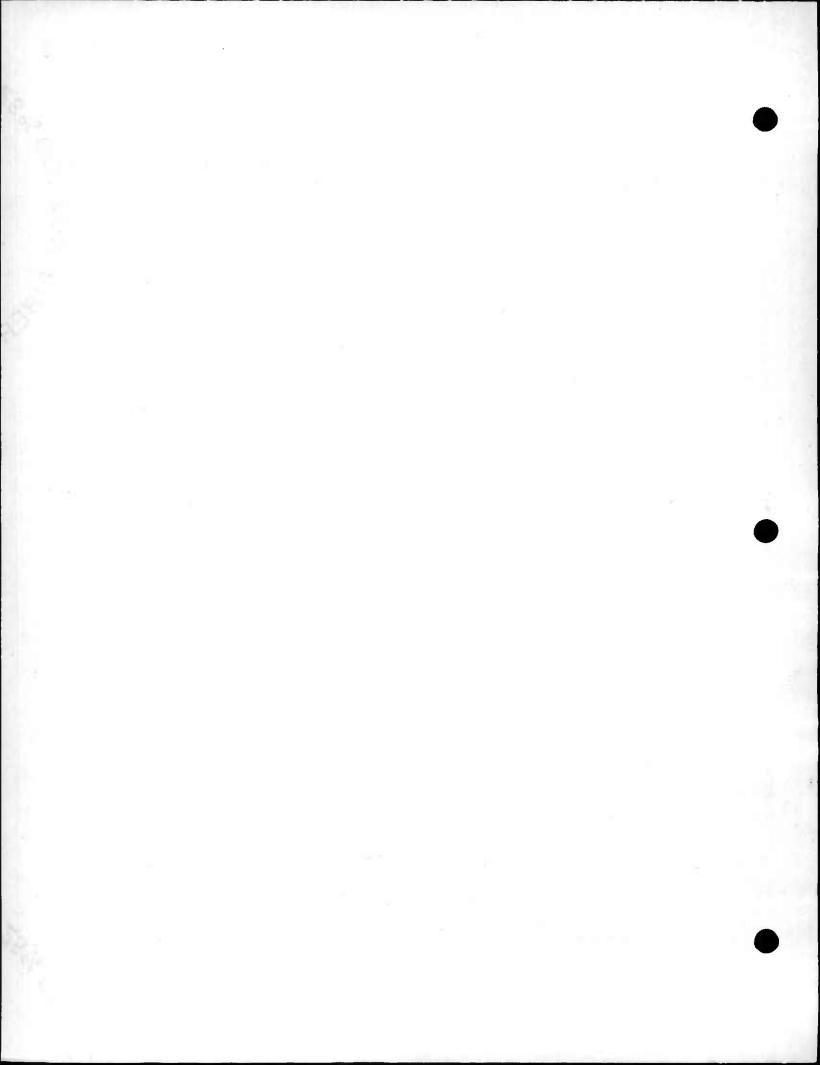
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		REGISTRAR				CERTIF	ICALE	OF	DEAL	Н		REG. NO.			
-		1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE O	F DEATN DA	٧	YEAR	3. TIME OF DEATN
`	1 1	BARBARA		JO			JOHNS	ON			APRI	L 18	, 19		04:30 A ^M
		4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER 1	$\overline{}$	IF UNDER		7. DATE O	F BIRTN Day, Year)		S. BIRTH Count	IPLACE (State or Foreign
	1 1	367-36-7205		1 🗆 M 2 💢 F	60	YRS.	MONTHS	DAYS	HOURS	MIN.	Mar 2	28, 19	35	000///	"KY
3 should	1 1	9e. FACILITY NAME (If not in	stitution, give st	treet end number)	-		9b. CITY, 1	O MWO	R LOCATIO	ON OF DE			9c. COU	NTY OF D	
	E E	SACRED HEA	RT HOS	PITAL			CUME	BERI	AND				ALI	LEGA	NY
1. 2.	DIRECTOR	RESIDENCE OF DEC													
Sages	H.	10a. STATE	10b. COUNTY				Y, TOWN OR	LOCAT	ION						10d. INSIDE CITY LIMITS?
±.		WV	Mine	ral		Ke	yser								1 TYES 2 1 NO
permit. Pages 1, 2,	FUNERAL	10e. STREET AND NUMBER							. ZIP CODI						WHAT COUNTRY?
. usit	띨	Route 2 Bo	x 144					_	26726				US		_
Sicla rial-tr	٦	11. MARITAL STATUS		12. WAS DECEDEN							NIC ORIGIN? In, Puerto Ri	(Specify Yee cen, etc.)	or No-	14. RAC Blac	E — Americen Indien, k, White, etc.
215-0020 attending physician se as the burial-tra	ВУ	1 Never Married 2 X 3 Widowed 4 Divo		IF YES, GIVE Y					2 X NO					Spec	
ending as the				CATION	1.	r- DECEDENT	I I OO	~ IDATIO	DAI .		165	KIND OF BUS	DINE CO /INI		white
	TED	(Specify onl	EDENT'S EDU	completed)		(Give kind of life. Do NOT u	work done du	iring mos	st of working	ng	160.1	KIND OF BUS	SINE 35/INI	DUSTRY	
	빌	Elementary/Secondery (0-12)	College (1-4 or 5	+}		111000					Own H	ama		
Thosp acher	ONCE.	12 17, FATNER'S NAME (First, A	Alatana I a al			Homema	rker		10 1107	UEDIO NA		ddle, Maiden			
/LAND 2				دا سال					120				Summer rej		
R A B B B G B G B G B G B G B G B G B G B		Anderson		ICK		T 405 44411 IN	G ADDRESS	(Ptenet s			le Kir		n Ctoto 7i	o Codel	
MARYLAND 21 retained by the hospital or 5 should be detached for u	TO B	li .													
n 9 9	2	Robert E.		on		Route				Ker	yser,				own, State
BALTIMORE, I er death. Page 6 may be the funeral director, page 8 val.	must	20e. METNOD OF DISPOSIT 1 D Burlet 2 X Cremetic	on 3 🗆 Rem	oval from State		PLACE AND DATE tery, cremetory or					1		iths	-	
MC age 6		4 Donation 5 Other		CENCEE		ni thsbu	rg Cre	emat	OTIU	IM SS OF FA	(U4/)	19 5111	TUISI	Jury	, 110
F. P.	ехатіпет	. /	L SERVICE LI	DENSEE /		201					neral	Home			
		Yare	1 +	DICO	w	IM			erlar			1502			
a a a	medical	23. PART V Entar tha					not antar t	the mo	da of dy	ing, suc	ch as cardi	ac or resp	iratory ar	rreat,	Approximate
Pours Se in the Contract of th		IMMEDIATE CAUSE (FI		List Dnly Dna ca	use on aa	ch lina.		`							Onsat and Dasth
	ž.	disesse or condition_		a. RE	Spir	ATORY	FAIL	UR	E						15 days
with with crem	event,	reaulting in death)		DUE TO	OR AS A	CONSEQUENCE	OF):								1
executed within 24 and completely fill to burial, cremation				. CA	RCIN	OMA 0	F Lu	NG	u	rTH	pu	emon)	4RY	7.	5 MONTHS.
exec to bu	traumatic ATION	Sequantially list condi- if any, lastling to imme											-		
BOX cate be ev	Fall Fa	cause. Entar UNDERLY	ING	c. Z	one	meT	ASTA.	52	5-						
.O. B(certificate ding physi tygiene pri	TIFIC	CAUSE (Disease or injuthat initiated events		DUE TO	OR AS A	CONSEQUENCE	OF):								
	ry, or other traumatic	reaulting in death) LAS	ST	d											
deat deat		PART II. Other algnific	ent condition	ne contribution t	death hu	t oot regultles	In the un	dodulo	COURS	alven In	Part I	24s. WAS AN	LAUTOPSY	24	b. WERE AUTOPSY FINDINGS
RD at the by th	any Injury,					177			72.0	-	- 1	PERFO	RMED7	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
CORDS	EDICAL	CARC	100101	308	ING	LOOK	0 1	ne	M	04	177	1 TYES 2	2 D NO		DF DEATH?
1 T								/_	• · · · · · · · · · · · · · · · · · · ·						1 YES 2 NO
> D =	23 st	DID TOBACCO U		RIBUTE TO CA				10		CERTAI	IN 🔲				
VITAL AN: The law tificate has e State Dep	ed, or item 23 shored PHYSICIAN: M	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:	2	8. PLACE OF DE	OTHER)						
F VIT,	YSI	1 TYES 2 NO		1 Ninpatient 2	☐ ER/Outpa	7	4 🗆 Nurs	ing Non		leeldence	8 🗆 Other				
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hi nours after death with the State D	PH IS	27. MANNER OF DEATN	Testin I	28e. DATE O (Month,	F INJURY Day, Year)	28b. T	ME OF	WC	JURY AT ORK?		28d. DE\$	CRIBE NOW	INJURY O	CCURED	
Z de la la la la la la la la la la la la la	marked BY PH	1 Netural 5 2 Accident	Pending Investigation				М		YES 2	NO NO					
NDING NDING St. After	# D	3 Suicide 8	Could not be		OF INJURY	— At home, ferm fy)	, atreet, fecto	ory, offic	Ce			ATION (Street or Town, State		er or Rurai	Route Number,
DIVISION OR ATTENDING F DIRECTOR: After I	7.28 TE	4 Nomicide	determined												
DIV OR A DIRECT HOURS	Item PLE	29e. CERTIFIER (Check only	TIFYING PHYS	SICIAN: To the best	of my knowle	edge, death occu	rred at the ti	me, dete	e end plac	e, end du	e to the ceu	se(e) end ma	nner ee st	ated.	
PITAL ERAL In 72	ANT: If item 2 COMPLET	anal .	DICAL EXAMIN	ER: On the besis of	examination	end/or investiga	tion, in my o	pinion, d	death occu	ured at th	e time, date	end place, e	nd due to	the ceuse	(e) end menner ee atsted.
THE HOSPITAL THE FUNERAL filed within 72	N O	29b, SIGNATURE AND TITL	E OF CERTIFIE	ER .					29c. LIC	CENSE NU	JMBER		29d. DA	TE SIGNE	D (Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL be filed within 72 I	8 H	31/1	la es	12	1	12-			D	2 0	638	/		APRII	10 1005
223	≥ 2	30. NAME AND ADDRESS	OF PERSON W	NO COMPLETED CA	USE OF DEA	TN (ITEM 27) (Ty	oe, Print)		<u> </u>	0~7	4 / 0		1 1	יו עדו	10, 1112
3		SATURNINA	T. 0	HANG K		FROSTB		DL	AZa	F	20ST1	BURG	MI) 2	1532
0		31. DATE FILEDIMMORP De	r Year)	37. FREGISTI	AR'S SIGN	ATURE D 10	-1769	1	1	1 1	-0-11	· · · · · ·			
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		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Last)	ME (First, Middle, Last)					3. TIME OF DEATH		
<u> </u>		242-28-1973	¹ 🗓 x № 2 🗆 F 68	in yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) an. 1, 192	Cou	THPLACE (State or Foreign nitry) h Carolina	
2, 3 should	TO BE COMPLETED BY FUNERAL DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington RESIDENCE OF DECEDENT								
permit. Pages 1,		10a. STATE 10b. COUNTY	nington	10c. CI1	Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
ışı,		10e. STREET AND NUMBER 964 Valley Road			101	21758		10g. CITIZEN OF	WHAT COUNTRY?	
TLAND ZIZIS-UUZU by the hospital or attending physician. be detached for use as the burial-transit at once.		1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO ATES	If yea, sp. 1 - YES	ecify Cuben, Maxicar 2 NO Specify		Bla	CE — American Indian, lick, White, atc.	
Z I Z I D- al or attendii for use as t		15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	(arch 1943 to TION (arch) (1943 to TION (arch)) (1944 or 5+)	18a. DECEDENT'S	USUAL OCCUPATION Work done during mose retired.)		16b, KIND OF BUS	I SINESS/INDUSTRY		
AND he hospita detached f		8		Office o	co-ordina		U.S. Gov			
		17. FATHER'S NAME (First, Middle, Last) Jacob Luther John	nson				ME (First, Middle, Maiden S Bell Goins			
retained 5 should		19a. INFORMANT'S NAME (Type/Print)					Poute Number, City or Town			
ay be	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of							DATE 20c. LOCATION — City or Town, State		
5 e g		4 Donation 5 Other (Specify)	Smi		Cremato	ry April	22, 1995 9	Smithsbu	rg, Maryland	
		Suchard C.C.	Pasford MC	00021	Keeney	y and Bas	sford Fune			
within 24 hours at pletely filled in by cremation, or remient, the medic		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, abock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 106 East Church St., Frodorick, Md. 21701 Approximate Interval Between Onset end Death Onset end Death Onset on CER DUE TO (OR AS A CONSEQUENCE OF):								
th certificate be executed by the certificate be executed by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate ce	4.5	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):								
w requires that the cheen signed by the or. of Health and Me shows any injury		PART II. Other eignificent conditions	contributing to death b	ut not resulting	In the underlying	g cause given in i	Part I. 24s. WAS AN PERFORI 1 YES 2	MED?	No. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF 0EATH? 1 YES 2 NO	
N: The fav ficate has State Dep	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:								
PHYSICIA this certif with the	ВУ РНУ	1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Raeldence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO NO NO NO NO NO NO NO								
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED B	3 Suicide 6 Could not be datarmined	Suicide 6 Could not be 26s. PLACE OF INJURY — At home, farm, street building, etc. (Specify)			actory, office 281. LOCATION (Street and Number or Rural Route Number City or Town, State)		Il Route Number,		
THE HOSPITAL OR A THE FUNERAL DIREC Flied within 72 hours PORTANT: It item	COMPL	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. Description of the best of the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
TO THE HOSPITAL (TO THE FUNERAL ID DE filed within 72 h IMPORTANT: IF IF	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUM	100 100						
	-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	-, B1	WZUNS	ICK,	My 2	1716		
		31. DATE FILEO (Month, Day, Year) APR 2 1 1995	32. RESISTBARY SIGN	uar Randall	3					



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are be executed within a nours after death. Page 6 may be retained	entificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-trans the State Dept of Health and Memal Huniese prior to having an emphasion for semanal	Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once
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MUN	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the finance after heart with the State Best of Health and Merital Homens mont to hund in remarkan	ent, t
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH KNIGHT HAZEL **JEANETTA** 0445 APRIL 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign 218-80-9344 1 M 2 F F 85 DAYS HOURS YRS December 28, 1909 Maryland Se. FACILITY NAME (If not institution, give street end number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10e. STATE 10c. CITY TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Parsonsburg Marvland Wicomico 1 YES 2X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21849 32544 Longridge Rd. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried It yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 K NO Specify: Specify: 3 X Widowed 4 Divorced White 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi (Give kind of work done life. Do NOT use retired.) Elemantary/Secondary (0-12) College (1-4 or 5+) 11 Housewife 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bruce Garfield MacAuley Mary Alice Jones 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Foley 32577 Longridge Rd., Parsonsburg, MD 21849 20e. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☑ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 Donation 5 Other (Specify) Salisbury Crematory 4/17 Salisbury, MD 21801 21. SIGNATURE OF FUNCTIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haert failure. List only one causa on eg intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Phenoconic reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? Cene buous aulou accident 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2 __ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner ee stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) L

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAP'S SIGNATURE

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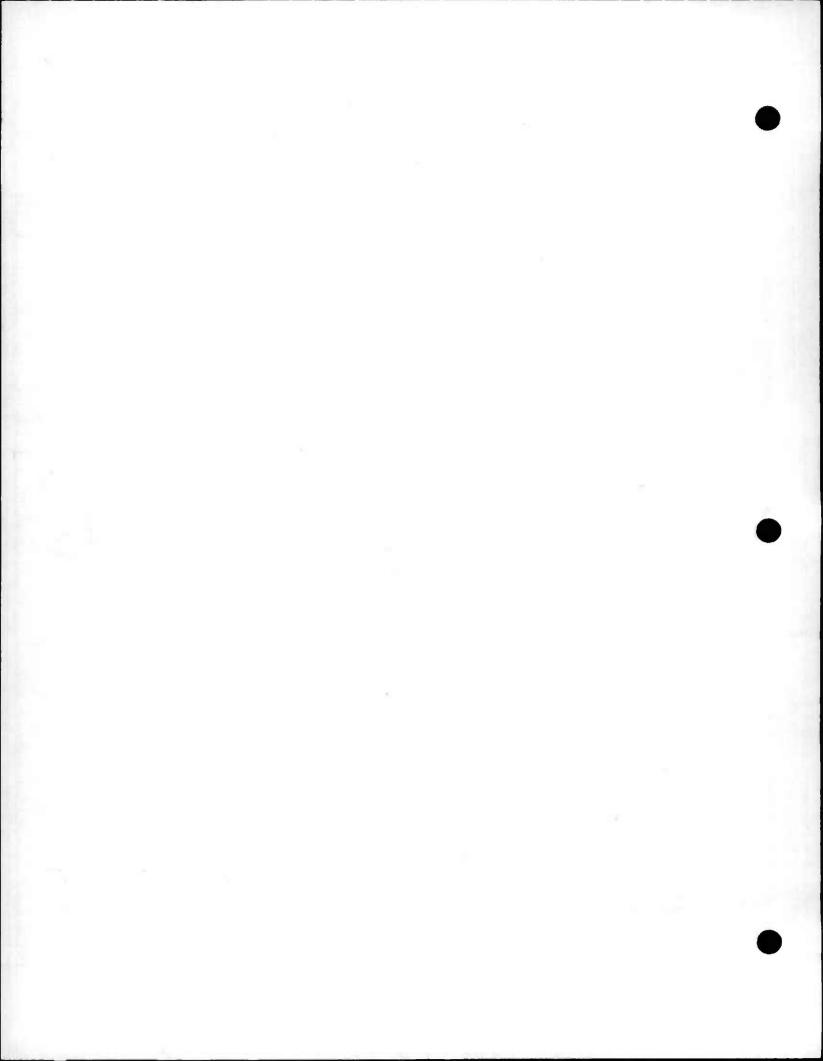
DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

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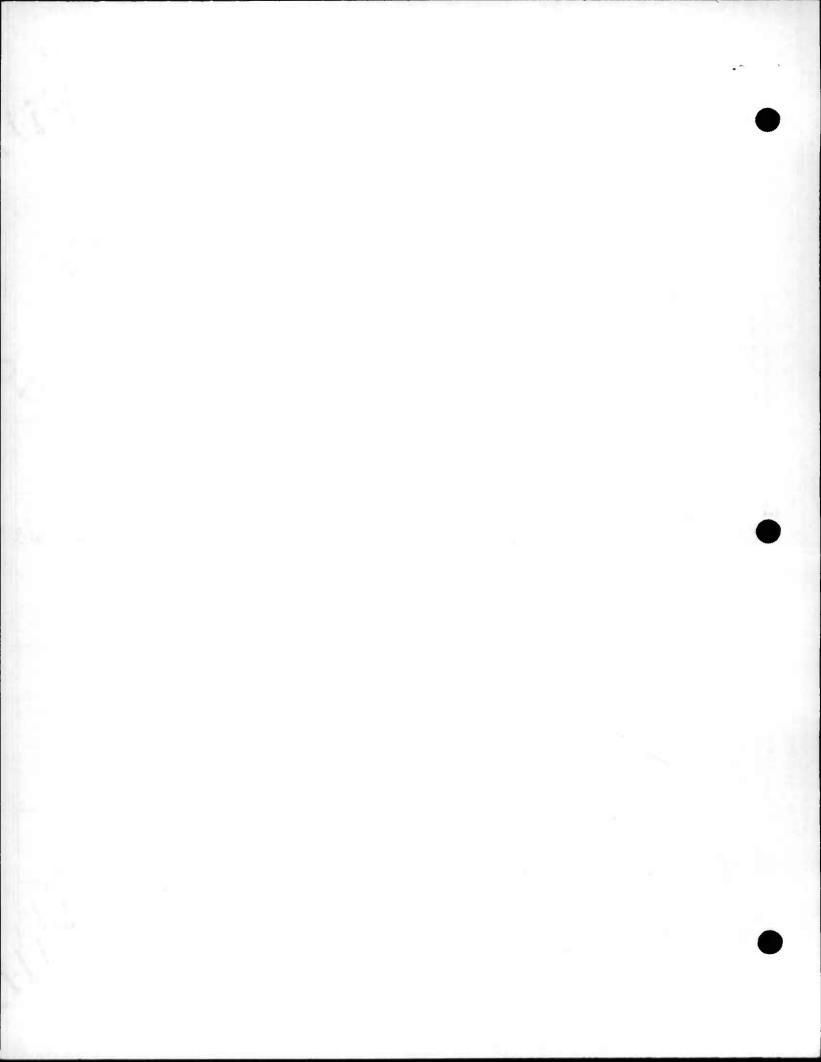
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DE	DAY	YEAR	3. TIME OF DEATN
	John	К.	Kill	ian					April		995	12:15am M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs	. last birthday)	IF UNDER		IF UNDER		7. DATE OF BIE	RTN	6. BIRTI	HPLACE (State or Foreign
	235-50-6745	1 😾 M 2 🗆 F	6	1 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, April		934	W. Va.
	Se. FACILITY NAME (If not institution, give a	treet end number)			9b. CITY,	TOWN (DR LOCATI	ON OF DE			OUNTY OF D	
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DIRECTOR	393 Jay Bea Ct				Gle	n I	Burn	1e		A	nne	Arundel
ا يَر	10s. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY
吉	MD Ann	e Arunde	1		Glen	Bı	rni	6				LIMITS?
	10e. STREET AND NUMBER				0 1 0 11	_	ZIP COD			100	CITIZEN OF	WHAT COUNTRY?
FUNERAL	393 Jay Bea Ct					"		_		10.00		MINI COUNTRY
ŽΙ	11. MARITAL STATUS	12. WAS DECEOENT	EVER IN U.S.	40400	1		210				SA	
	1 Never Married 2 Nerried	FORCES? 1-	YES 2	NO	13. 4	yes, sp	ecify Cube	n, Mexican	C ORIGIN? (Spe , Puerto Rican,	elty Yes or No- etc.)	- 14. RACI	E American Indien, k, White, atc.
à	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1	YES	3 ^X □ NO	Specify:			Spec	<i>™:</i> White
	15. DECEDENT'S EDU	CATION	100	. DECEOENT'S	HEHAL OC	CHIBATI	201		401 40040		1	MILLE
	(Specify only highest grade	completed)		(Give kind of a	work done d	luring mo	st of working	ng	100. KIND	OF BUSINESS	INDUSTRY	
ا ټ	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+							n a			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	7.7	1	eache	r					ucati		
				_					AE (First, Middle,		-,	
W	Jake She	lby	Kil	lian					Evel			
2	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street e	nd Number	or Rural A	oute Number, City	or Town, State,	Zip Code)	
_	Twila Killian			393	Jay	Веа	a Ct	. G1	len Bu	rnie,	MD	21061
	20e. METHOO OF DISPOSITION 1 Burlel 2 Cremation 3 Rem	ovel from State		CEANDDATE		TION (Na	me of		OATE	20c. LOCATION	— City or To	own, State
ı	4 Donation 5 Qther (Specify)			Vete		C.	m .	4	/ 28	Crown	svil	le, Md
-1	21. SIGNATURE OF FURERAL SERVICE LI	TENGLEE /						SS OF FAC				
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-	100	you	w	Cyl	Ва	rra	anco	FΗ	Sever	na Pa	rk,	MD 21146
	23. PART I Enter the diseases, or shock, or heart fellure.	complications that List only one caus	caused the	deeth. Do r	not enter	the mo	de of dyi	ng, auch	aa cardlec o	r respiratory	arreat,	Approximate
ļ	IMMEDIATE CAUSE (Final			/ .	_	1						Interval Between
İ	disease or condition resulting in death)		/	Cuny		(5	me	e				H YM
- 1	in death)	DUE TO (C	OR AS A CON	SEQUENCE	n:			_				1
z I	and the state of t			(1								
일	Sequentially list conditions, if any, leading to immediate	DUE TO (C	R AS A CON	SEQUENCE OF	F):							
CERTIFICATION	cause. Enter UNDERLYING	•										
	CAUSE (Disease or injury that initiated events	DUE TO (C	R AS A CON	SEQUENCE OF	F):					···		
F	resulting in death) LAST	4										
5		V.										
ا ہے	PART II. Other significant condition	a contributing to d	eath but no	ot reculting	In the und	deriying	cause g	iven in F	Part I. 24a, 1	MAS AN AUTOPS	SY 24b	. WERE AUTOPSY FINDINGS
EDICAL										YES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_ ' ' '	ies Cono	2	OF DEATH?
Σ	DID TOBACCO USE CONTI	RIBLITE TO CALL	SE OF D	FATH VE	S \square N	10 [LING	EDTAIN				1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	LIBOIL TO CAU		LACE OF DEAT			UNC	CKIAIN				
ا ق	EXAMINER?	HOSPITAL:	1001		OTHER	:						
<u> </u>	27. MANNER OF DEATH	1 Inpetient 2 I			4 Nursi		_		Other (Spec			
ž	Natural 5 Pending	26e. DATE OF IN (Month, Day,	Year)	26b. TIM	URY		RK?		26d. DEŞCRIBE	HOW INJURY	OCCURED	
À	2 Accident Investigation				M .	1 🗆 1		NO.				
2	3 Suicide 6 Could not be 4 Nomicide determined	26e. PLACE OF building, at	INJURY — At c. (Specify)	t home, ferm, s	street, facto	ry, office			26f. LOCATION City or Town		ber or Rural F	Route Number,
: 1	4 Nomicide determined											
Z	29a. CERTIFIER (Check only	CIAN: To the best of m	y knowledge,	, death occurre	d at the tir	na, date	end place.	end due t	o the cause(e) o	nd manner ee	stated	
COMPLE	one) 2 MEDICAL EXAMINE											and manner en stated
- 11	29b. SIGNATURE AND TITLE OF CERTIFIES											
M H	230 SIGNATURE AND THEE OF ALPHINE		7	X		7.	29c. LICE	NSE NUMI	BER O	29d. D	ATE SIGNED	(Month, Day, Year)
5		/	VA)		17	18	501		4/27	185
	30. NAME AND ADDRESS OF PERSON WIN	O COMPLETED CAUSE	DF OEATH (I	TEM 27) (Type,	-		7	(t	1
	Charles J. Wu . 1	1.D. 1600	5 Cro	in H	WU	世3	06 (alen	Burr	ie .1	yd .	2106/
	31. DATE FILEO (Month, Dey, Year)	32. REGISTRAR	S SIGNATUR	E						7		
	APR 27 1995	Julia Dan	clearKe	Mobile								



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING DHYSICIAN. The law requires that the death certificate he executed with
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		1. DECEDENT'S NAME (First, Middle, Last)			CERTIF	TOATE OF	DEATH	2. DA	REG. NO.		3. TIME OF OEATH		
		Margaret E.	llen	Keen	ey			MO	04 DA	26	95 4107PM		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. lest birthday)	IF UNDER 1 YEAR		- " " " "	TE OF BIRTH onth, Day, Year)		B. BIRTHPLACE (State or Foreign Country)		
밀		212-24-3569	1 🗆 M 2 💢 F	7	6 YAS.	MONTHS DAYS	HOURS MIN.	77	10/191	8	Maryland		
3 should	00	9s. FACILITY NAME (If not institution, give to	Merch Edder				OR LOCATION OF				TY OF DEATH		
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Pages	DIRECTOR	10e. STATE 10b. COUNT				Y, TOWH OR LOC					10d. INSIDE CITY		
Ji.	1 1		roll		W	estmin	ster				1 YES 2 NO		
it per	RAI	10e. STREET AND NUMBER				1	Of. ZIP CODE				EN OF WHAT COUNTRY?		
the burial-transit permit.	FUNERAL	45 John Owing:	S Road 12. WAS DECEDEN	T EVER IN III	Antien	1 40 1110 0	21158				ted States		
burial		1 Never Married 2 Merried	FORCES? 1	YES 2	NO	If yes, s	ECENDENT OF HISF	Ican, Puar	GIN? (Specify Yee to Ricen, atc.)	or No— 1	14. RACE — American Indian, Black, White, etc.		
s the	ВУ	3. Widowed 4 Divorced	1 725, 372 7	with Off Oxize		1 1 18	S 2 NO Spe	эспу:		_	Specify: White		
for use as	TEO	15. DECEDENT'S EDU (Specify only highest grade		164	(Give kind of	USUAL OCCUPAT	TION nost of working	1	16b. KIND OF BUS	INESS/INDU			
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be detached at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			worke	<u>r</u>	to MOTHERINA		Black		cker		
8 8	O O	Joseph Clar	ence :	Stock	sdale		Marga		t, Middle, Maiden : Han	nah	Smithson		
5 should notified	0 8	19e. INFORMANT'S NAME (Type/Print)		3000,1	_	ADDRESS (Street	and Number or Run						
e not		Judy Ann Owing	gs								er, MD 21158		
must b		20e. METHOD OF DISPOSITION 1 XBuriel 2 Cremetion 3 Rem	oval from State	20b. PL/	ACE AND DATE	OF DISPOSITION //	Name of 1/28/	/95°	ATE 20c, LOC	ATION — CI	fy or Town, State		
directic		4 Donation 5 Other (Specify)) i ordinatory or c	n Memo	rial Ga	arde		nksb	urg, MD		
neral Imin		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE				tts Fur		1 Home	& C	hanel		
the fu		Kotherine 4	Pitto - V	Tweeth	ur	412	Washir	nato	n Rd.,	Wes	tminster, MD		
and completely filled in by the funeral director, page o burial, cremation, or removal. natic event, the medical examiner must be in		23. PART I. Enter the diseases, or ahock, or heart feliure. IMMEDIATE CAUSE (Final	complications the	t caused (h	line.	not anter tha m	ode of dying, au	uch aa c	ardiec or respir	ratory erre	et, Approximate interval Between Onset end Death		
emation that		disease or condition											
rial, c	_	DUE TO (OR AS A CONSEQUENCE OF):											
anding physician and c Hygiene prior to buria or other traumatic	TIO	Sequentially liet conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):											
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CAUSE (Disease or injury that initiated evente OUE TO (OR AS A CONSEQUENCE OF):													
Hygik	RTIF	cause. Entar UNDERLYING	с										
e attending lental Hygiv ury, or ol	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	c. OUE TO	(OR AS A CO	NSEOUENCE O	F):							
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has been signed by the atte Dept. of Health and Mental 1 23 shows any Injury,	SICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT	d. OUE TO d. RIBUTE TO CA	deeth but n	nsequence of resulting	in the underlyle	UNCERTA	AIN IZ	PERFORI	MED?	AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?		
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After this certificate has been signed by the after death with the State Dept. of Health and Mental s marked, or Item 23 shows any Injury,	ETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2	c. OUE TO d	daeth but n USE OF D 26. F ER/Outpetier INJURY ay, Year)	DEATH YE	in the underlying the control of the	UNCERTA UNCERTA UNCERTA DIURY AT ORIC? YES 2 \(\text{NO} \) NO	28d. 0	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN	MED?	AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
AL DIRECTOR: After this certificate has been signed by the after 72 hours after death with the State Dept. of Health and Mental If Item 28 is marked, or Item 23 shows any Injury,	ETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DATO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29s. CERTIFIER Check only 1 CERTIFYING PHYSI	CAN: To the beat of	daeth but in USE OF D 26. F ER/Outpetier INJURY ay, Year) F INJURY — A etc. (Specify)	DEATH YE PLACE OF DEA 1 DOA 28b. TIM	in the underlying in the under	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA DESCRIPTION ORK? YES 2 NO ce e end place, and de	28d. 0	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN DOCATION (Street at lift) or Town, State)	MED? NO JURY OCCU	AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO RED RED		
AL DIRECTOR: After this certificate has been signed by the after 72 hours after death with the State Dept. of Health and Mental If Item 28 is marked, or Item 23 shows any Injury,	COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TOO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29s. CERTIFIER (Check only One) 1 CERTIFYING PHYSI (Check only One) 2 MEDICAL EXAMINE	C. OUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpettent 2 28e. DATE OF (Month, D 28e. PLACE O building,	daeth but in USE OF D 26. F ER/Outpetier INJURY ay, Year) F INJURY — A etc. (Specify)	DEATH YE PLACE OF DEA 1 DOA 28b. TIM	in the underlying in the under	UNCERTA) me 5 Rasidence JURY AT ORK? YES 2 NO ce e end place, and do death occured at ff	28d. 00 28d. 00 28t. LC	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN DOCATION (Street at lift) or Town, State)	MED? NO JURY OCCU And Number or ner se stated I due to the	AMILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO RED RUTAL Route Number,		
AL DIRECTOR: After this certificate has been signed by the after 22 hours after death with the State Dept. of Health and Mental If Item 28 is marked, or Item 23 shows any Injury,	BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TATO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29s. CERTIFIER (Check only One) 2 MEDICAL EXAMINE 29b. SIGNATURE AND RYLE OR GERTIFIES	C. OUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building,	daeth but in USE OF D 26. F ER/Outpetier INJURY oy, 'Year') F INJURY — etc. (Specify) my knowledge camination enc	DEATH YE PLACE OF DEATH IN IN IN IN IN IN IN IN IN IN IN IN IN	in the underlying the control of the	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA DESCRIPTION ORK? YES 2 NO ce e end place, and de	28d. 00 28d. 00 28t. LC	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN DOCATION (Street at lift) or Town, State)	MED? NO JURY OCCU And Number or ner se stated I due to the	AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO RED RED		
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THE FUNERAL DIRECTOR: After this certificate has been signed by the arts filled within 72 hours after death with the State Dept, of Health and Mental PORTANT: If Item 28 is marked, or Item 23 shows any Injury,	BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST PART II. Other eignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 1000 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29b. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TYPLE OR GERTIFIER 30. NAME AND ADDRESS OF PERSON WH 31. DATE FILEQ ((Month, Day, Yes))	C. OUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building,	daeth but in USE OF D 26. F 27. Second of the second of	DEATH YE PLACE OF DEATH 11 3 DOA 28b. TIM No. death occurrence of dor investigation (ITEM 27) (Type)	in the underlying the control of the	UNCERTA) me 5 Rasidence JURY AT ORK? YES 2 NO ce e end place, and do death occured at ff	28d. 00 28d. 00 28t. LC	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN DOCATION (Street at lift) or Town, State)	MED? NO JURY OCCU And Number or ner se stated I due to the	AMILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO RED RUTAL Route Number,		

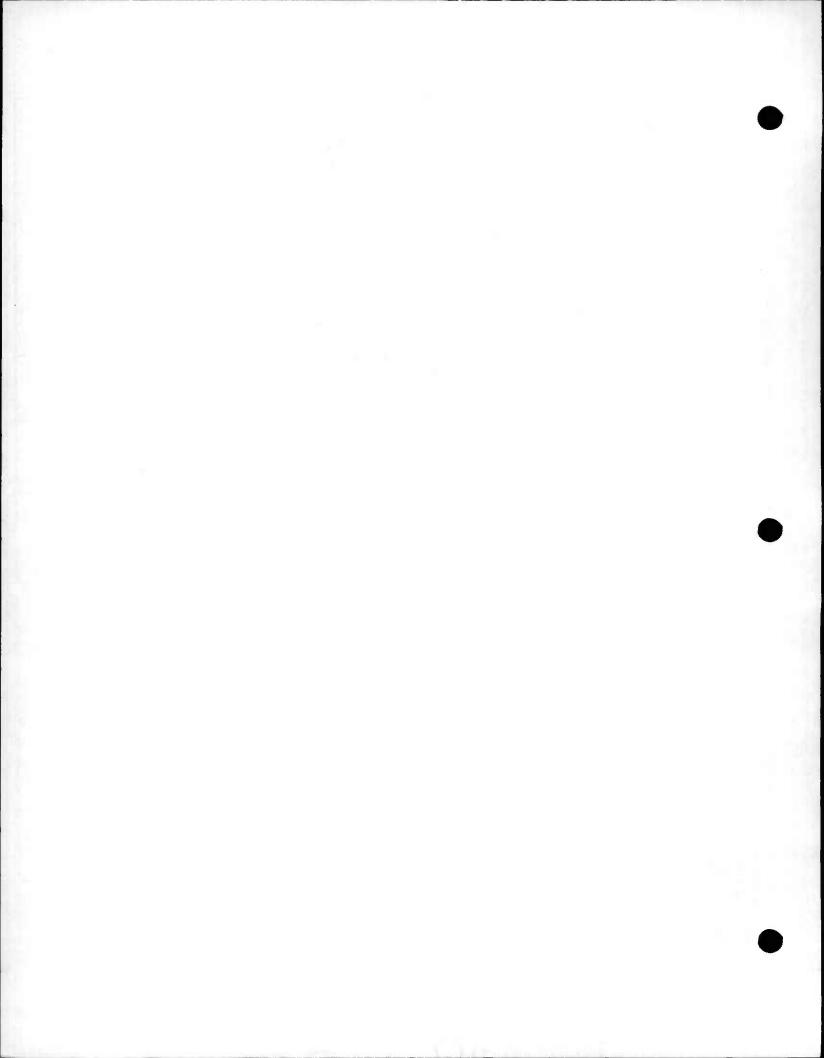


1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF	DEATH		-	3. TIME OF DEATH
3		G	eraldi	ne NA	4N	Kuh	n				MONTH	D/	1995	YEAR	
		4. SOCIAL SECURITY NUME		5, SEX	6. AGE (In yrs.			1 YEAR	IF UNDER	D 24 MIDS	7. DATE OF		1995	_	10:20P M
		214-34-449		1 M 2 M F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, L	6-19	10	Count	
pinous		9a. FACILITY NAME (If not in					Bh CITY	TOWN	OR LOCATI	ON OF D		0-19	9c. COUN	TV OF F	
60	2	Lorien-R			na Hom	16			camp		EAIR			larf	
1, 2,	6	RESIDENCE OF DEC	EDENT					-	camp					Tar I	oru
Pages	2	10a. STATE	10b. COUNTY			10c, Cf	TY, TOWN O								10d. INSIDE CITY LIMITS?
permit. F	ā	MD		Harford			Н	_	e de		ace				1 X YES 2 NO
	ERAL	10a. STREET AND NUMBER		t				-10	of. ZIP COO				10g. CITIZ		VHAT COUNTRY?
D20 physician. bunal-transit	N.	829 Ont	ario 5	Treet						078					SA
020 physician burial-tra	FUN	1 Never Married 2	Married	FORCES? 1	YES 2			f yes, s	pecify Cubi	nn, Mexica	NIC ORIGIN? (in, Puarto Ric	Specify Yea an, etc.)	or No-	14. RACI Biac	E — Americen Indian, k, Whita, atc.
	3 ☐ Wildowed 4 X Divorced IF YES, GIVE WAR OR DATES 1 ☐ YES 2 X NO Specify: Specify:							"y: White							
LAND 21215-0 the hospital or attending detached for use as the once.	日日	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY													
27 al or for u	Ē	Elementery/Secondary (0		College (1-4 or 5	+}	life. Do NOT	use retired.)	Juning III	OST OF WORK	ng.					
AND he hospit detached once.	COMPL	11				Н	omem	ake	r				Horr	ie	
the hose detach	8	17. FATHER'S NAME (First, M							18. MOT		ME (First, Mid		,		
ed by	BE	Robe	·- ·	sse Cra						-	cile El	_			
MARYLA retained by the 5 should be det notified at on	2	Mr. Richard	,,	up wfoud							Ploute Number,				24070
00 00		20a, METHOD OF DISPOSIT		rawiord	200 21 22					нач	re de	1			
TIMORE, Page 6 may but director, page		1 Burtal 2 Crematic	n 3 🗆 Rem	oval from State	cemetery,	EANODATE Crematory or OKVIE	other place)	ITION (A	leme of		OATE		CATION — C	-	- 10/
Page I dire		21. SIGNATURE OF FUNERA		ENSEE	- D100	okvie	22.	NAME A	NO ADDRE	SS OF FA	CILITY				, Maryland
ALTIN death. Pag tuneral di i. examiner		1 200	. 72-	00			ÍVÍ	itch	iell-S	mith	Fune	eral l	Home,	Ρ.	Α.
BAL is after death is by the fune removal.		- Carlo	la	-O- DA	~~~						ce, i				97
hours after death, Page 6 ed in by the funeral direction or removal.	1	23. PART i. Enter the d shock, or h	iseeses, pro esrt failura.	Dist only one car	et caused the use on each ii	deeth. Do na.	not enter	the m	ode of dy	Ing, suc	h es cerdle	c or respi	ratory arre	est,	Approximete interval Between
8 = 8 = 8		IMMEDIATE CAUSE (Fir	ese or condition											Onset and Dasth	
ted within 24 completely fill (al, cremation, the		resulting in death)	→	Septic	emia	SEQUENCE A	_								1 Week
con rial.	_														
	ō.	Sequentially list condition if any, leading to imme-		DUE TO	ry Trac	SEQUENCE (rection:	n							3 Weeks
certificate be ding physiciar dygiene prior other trau	CATIO	cause. Enter UNDERLY!	ING	Pneum	nonia										1 Week
riffica rig phy giene	RTIF	that initiated events		OUE TO	(OR AS A CONS	SEQUENCE (DF):								
ath ce	m ii	resulting in death) LAS	' L	d											
the dea y the att of Menta Injury.	7 T	PART II. Other significa	nt condition	s contributing to	death but no	t resulting	In the un	deriyir	ng ceusa	given in	Part i. 2	4a. WAS AN	AUTOPSY	246	. WERE AUTOPSY FINDINGS
that the the the the the the the and the and any Ir	ICAL					10.00			· · · · · · · · · · · · · · · · · · ·			PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
Signe Health	EDI										_ '	YES 2	₹ NO		DF DEATH?
L KECORDS, P. O. I was required that the death case as been signed by the attendit of Health and Mental Hy, or o. 23 shows any Injury, or or	¥.	DID TOBACCO	O USE O	CONTRIBUTE	TO CAL	USE O	DEAT	H	YES [1 NC	- FR				1 NES 2 NO
AL he law he law he be bept.	A	25. WAS CASE REFERRED TO									eck only one)				
Certificate has the State Dep	PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER 4 Num	R: Na Ho	me 5 🗆 Re	esidence	8 Other (S	Specifyl			
HYSICIA HYSICIA his certif with the	美	27. MANNER OF OEATH		28a. DATE OF (Month, E		28b. Til		28c. IN	JURY AT ORK?		28d. OESCF		NJURY OCC	UREO	
NG PHYS fer this c eath with marked,	BY		Pending Investigation	(MONN), E	, 10m/		M		YES 2	□ NO					
ATTENDING PHYSICIAN: The law re ECTOR: After this certificate has bee a fifer death with the State Dept. o 28 is marked, or item 23 st	0	3 Sulcide 6	Could not be	28a. PLACE C building	of INJURY — At etc. (Specify)	home, ferm,	street, fact	ory, offi	ce			ON (Street a Town, State)	and Number	or Rural I	Route Number,
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	COMPLETE	4 Homicide	determined								,				
L DIRECT Phours	2	29e. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	f my knowledge,	death occur	red at the t	lme, dat	a and place	, and dua	to the cause	(a) and mar	ner aa atate	id.	
SPITAL NERAL hin 72 NT: If	O	one) 2 MEO	ICAL EXAMINE	R: On the basis of s	xamination end/	or Investigati	ion, in my o	pinion,	death occu	red at the	time, date en	d place, en	d due to the	cause(e	e) end manner as stated.
E HO	BE C	29b. SIGNATURE AND THE		3					29c. LIC	ENSE NU	MBER		29d. DATE	SIGNED	(Month, Day, Year)
TO THE HOSPITAL (TO THE FUNERAL DE FIGE WITHIN 72 PA			am	-m)	*				D	3260	9		► A	pril	25, 1995
	임	30. NAME AND ADDRESS.Q	PERSON WH	O COMPLETED CAU	SE OF DEATH (I	TEM 27) (Typ	e, Print)								
		Kamrudin N	lithani	, M.D.,	703 R	evolu	tion	St.	, Ha	vre	de Gr	ace,	MD 2	2107	8
		31. DATE FILED (Month, Day, APR 26	rear)	32. HEGISTRO	AN'S SIGNATURE										

	_	1 - FOR STATE REGISTRAR	STATE OF N					EALTH AN DEATH	D MEN	TAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)								TE OF DEATH	AY Y	EAR 3.	TIME OF DEATH	
		Russell Madisor	Keiste							rch 30,	1995		6:30 P.	М
		220-10-0715	1 X M 2 F	6. AGE (In yrs. le		IF UNDER 1	DAYS	HOURS MI	N. (M	TE OF BIRTH onth, Day, Year)		Country)	ACE (State or Foreign	
pinou		9a. FACILITY NAME (If not institution, give		13		9b; CITY, 1	TOWN O	R LOCATION O		10,	1915 W		Virginia	_
, 3 8	S S	4119 56th Avenue				Blad					Prince			
	2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT				TOWN OR								
15-0020 ending physician. as the burial-transit permit. Pages 1, 2, 3 should	DIRECTOR	100000	e George			lensb		ON					LIMITS?	
permit		10e. STREET AND NUMBER	e dedige	3	Diac	tenso		ZIP CODE			10g. CITIZE		AT COUNTRY?	_
in. ansit	FUNERAL	4119 56th Avenue						20710			Unite	d S	tates	
20 Nysicia urfal-tr	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	T EVER IN U.S. A VES 2 MA OR DATES	RMED	13. W	AS DECE	NDENT OF NE	SPANIC ORI	GIN? (Specify Yes	or No — 14	RACE -	American Indian, Vhita, etc.	
fing p	B	3 Wildowed 4 Divorced	World Wa					2 NO S		., .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:	White	
215 attend	<u>Q</u>	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. D	ECEDENT'S U	SUAL OCC	CUPATION	N		16b. KIND OF BU	SINESS/INDUS	TRY	WILLE	_
tal or lifer u		Elementary/Secondary (0-12)	College (1-4 or 5 +	-)	e. Do NOT use	retired.)	mig mos	t or working						
LAND 21215-0020 the hospital or attending physician, detached for use as the burfal-tran	once. COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Pa	ainter					Paintir		any		_
YLAND 212- by the hospital or att be detached for use	a co	Robert Keister						Emma		st, Middle, Malden	Surname)			
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial	S 0	19a. INFORMANT'S NAME (Type/Print)		19	96. MAILING /	ADDRESS (Street an			umber, City or Tow	n, State, Zip Co	c(e)		-
(P) (E)	TO TO	Clara B. Keister								sburg,			20710	
	must b	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem	oval from State	20b. PLACE	AND DATE OF	DISPOSIT	ION (Nan	ne of	D	ATE 20c. LO	CATION - CIT	or Town	State	
ALTIMORE death. Page 6 may funeral director, pa		4 Donation 8 Other (Specify)	DENGEE .	Fort	Linco	In Co		ery o		5 Bre	ntwood	, Ma	ryland	
LT eath.	examiner	· X	His	4		For	rt I	incoln	Fun	eral Ho				
B B after of n by the removal.		23 PART I Enter the diseases or	-/-J/CC	uC									MD 20722	
	medical	23. PART T. Enter the diseases, Dr ahock, Dr heert fellure.	List Doly Doe ceu	se Dn each lin	e.	t enter ti	he mod	e of dying,	auch ea c	erdiec or resp	Iratory arrea	•	Approximata interval Between	
42 fill fill fill fill fill fill fill fil	흑	immediate cause (Final disease or condition	Adv	nnce	Cu	vu's	~ ~~	2 2	Im	beer		Onset and Das	th	
ted within completely ial, cremati	event	reaulting in death)	DUE TO	(OR AS A CONSE	OUENCE OF)			40 0			4.		120	
executed within and completely burial, creman		Sequentially list conditions,	D. 1 1	mg m									2 cm	
Cian be	traumatic ATION	if any, leeding to immediate cause. Enter UNDERLYING		OR AS A CONSE			P	1 -	.11.	1.0. (.			,)	
Phy phy	other 1	CAUSE (Disease or injury that initieted events	**	OR AS A CONSE			7	w~ 2	NI	- oour	8		1 No	
Q = 5 =	히뜌	resulting in death) LAST	d	nen:	- ~								1 Mo	
RDS, F at the death by the atter	shows any injury, MEDICAL CI	PART II. Other eignificant condition	a contributing to	death but not	resulting in	the unde	erivina	ceuse given	in Pert I	24s. WAS AN	AUTOPSV	245 WI	RE AUTOPSY FINDING	
ORE that the ed by the and	any inju				_		,	3		PERFOR	IMED?	AW	AILABLE PRIOR TO EMPLETION OF CAUSE	0
w requires that been signed pt. of Health a	MEC									1 TYES 2	WWw		DEATN?	
	23 sh	DID TOBACCO USE CONT	RIBUTE TO CAI					UNCERT	AIN 🗆					
一年 ##	red, or item 23 shows a PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEATN	OTHER.								
F C SICIAN Certifie	HYS	1 YES 2 NO 27. MANNER OF DEATN	1 Inpetient 2		26b. TIME	7	6c. INJU	5 X Residen						_
/ISION OF VI: ATTENDING PHYSICIAN: CTOR: After this certifical s after death with the St	marked, BY PI	1 X Natural 5 Pending	(Month, Da	ty, Year)	INJU	RY	WOR	K? 1 S 2 \(\bar{\cap}\) NO	20d. L	EŞCRIBE HOW I	NJURY OCCUR	ED		
NDING INDING I		3 Suicide 6 Could not be	26e, PLACE OF	F INJURY — At he	ome, farm, str	eet, factory	y, office			OCATION (Street	and Number or i	Rumi Rout	Number,	_
DIVISION OR ATTENDING I DIRECTOR: After hours after death	ETE ETE	4 Nomicide determined								ity or Town, State)				
로 날 다 다	ANT: If item 28 is COMPLETED	29a. CERTIFIER (Check only one)	CIAN: To the best of	my knowledge, de	eath occurred	at the time	e, data a	nd place, and	due to the	cause(a) and mar	ner se stated.			
TO THE HOSPITAL TO THE FUNERAL De filed within 72	N O	2 MEDICAL EXAMINE		amination and/or	Investigation,	In my opli	nion, des	nth occured at	the 11me, de	rte and place, an	d due to the co	iuse(a) an	d manner as stated.	
THE P	POR POR	296. SIGNATURE AND TITLE OF CERTIFIE	3226	mn				29c. LICENSE					onth, Day, Year)	
2 2 3	≥ 2	30. NAME AND ADDRESS OF PERSON WH			M 27) (Topo 6	rint)		017	211	9	P 3	311	61	_
(10)		Mahmoodullah Baig					veni	ie, #14	400.	Riverda	le. MT	20	737	
		31, DATE FILED (Month, Day, Year)	32. REGISTRAF	R'S SIGNATURE		J 11	. 0110	, "I"	.00,	TTVELUA	للتا وعد	20	,,,,,,	\dashv
		APR 10 1995 Jul	a Davelson	Kardall										



DIVISION OF VITAL RECORDS. P.O. BOX 68760	THE FUSETIAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNETAL CIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, the final man that share and Marial Avriance prior to burial companies or companies.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL	O THE HUSPITAL OR ATTENDING PHYSICIAN. THE ION OF THE FLINEFAL CIRECTOR. After this certificate has be find within 20 hours after death, with the Strate Death.	MPORTANT: If item 28 is marked, or item 23

2

2, 3 should

FOR STATE REGISTRAR TO BE COMPLETED BY FUNERAL DIRECTOR BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

William Andrew King 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. OATE OF BIRTH (Month. Day, Ybar) 5. TO ATE OF BIRTH (Month. Day, Ybar) Sept. 26, 1929 9. FACILITY NAME (If not institution, give street and number) Golden Oaks Nursing Home FINAL STATE 10b. COUNTY Maryland Prince George's 10c. CITY, TOWN OR LOCATION Maryland Prince George's 10d. INSIDE CITY Maryland Prince George's 10d. INSIDE CITY 10d. STREET AND NUMBER 9001 Cherry Lane 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuben, Mexicen, Puerfo Rican, atc.) 10 YES 2 NO Specify: Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 2 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 11. Yes 3 NO Specify: 12. Yes 3 NO Specify: 13. Yes 3 NO Specify: 14. RACE — American Indian, Black, White, etc. 15. Yes 2 NO Specify: 16. AGE (In yrs. last birthday) 17. Yes 4 Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify: 18. BIRTHPLACE (State or Foreign Country) 19. Sept. 26, 1929 10. Sept							
4. SOCIAL SECURITY NUMBER 5. SEX 1							
9e. FACILITY NAME (If not institution, give street and number) Golden Oaks Nursing Home FAESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Prince George's 10c. CITY, TOWN OR LOCATION Maryland Prince George's Laurel 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 10d. CITIZEN OF WHAT COUNTRY? 20708 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, etc. 15. Yes 2 No Specify: 1 Yes, specify Cuben, Mexicen, Puerio Rican, atc.) 1 Yes, Specify: Specify:							
Golden Oaks Nursing Home RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Prince George's Laurel 10c. CITY, TOWN OR LOCATION Laurel 10d. INSIDE CITY LIMITS? 1 Never Married 10g. CITIZEN OF WHAT COUNTRY? 20708 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Never Married 1							
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Prince George's Laurel 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. ZIP CODE 10f. CITIZEN OF WHAT COUNTRY? 20708 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 1 Never Married 1 Never Married 2 Merried 1 Never Married 1 Never							
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 20708 U.S.A. 1. MARITAL STATUS 1 ☑ YES 2 ☐ NO 10 Never Married 2 ☐ Merried 1 ☐ Never Married 2 ☐ Merried 1 ☐ Never Married 2 ☐ Merried 1 ☐ Never Married 2 ☐ Merried 1 ☐ YES 2 ☐ NO 1 ☐ YES 2 ☑ NO 1 ☐ YES 2 ☑ NO 1 ☐ YES 2 ☑ NO 1 ☐ YES 2 ☑ NO 1 ☐ YES 2 ☑ NO Specify Spe							
Maryland Prince George's Laurel Maryland Prince George's Laurel Maryland Prince George's Laurel Maryland Prince George's Laurel Maryland							
106. STREET AND NUMBER 9001 Cherry Lane 107. ZIP COOE 109. CITIZEN OF WHAT COUNTRY? U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. YES 2 NO Specify: 16. ZIP COOE 17. ZIP COOE 18. RACE — American Indian, Black, White, etc. 19. VES 2 NO Specify: 109. CITIZEN OF WHAT COUNTRY?							
9001 Cherry Lane 11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. YES 2 NO Specify: Specify:							
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Merried 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. YES, GIVE WAR OR DATES 16. YES, 2 NO Specify: Specify:							
1 Never Married 2 Merried FORCES? 1 X YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, atc.) Black, White, etc. 1 YES 2 NO Specify: Specify: Specify:							
3 Widowed A IV Observed							
White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INOUSTRY							
Elementary/Secondary (6-12) College (1-4 or 5+) 7							
/ Landscaping Landscaping Industry 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Surgange)							
Training Training Training							
Ephraim Zacharias King Willie Lee Mays 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Paral Route Number, City or Town, State, Zip Code)							
Wanda Costanzo 4413 75th Avenue, Landover Hills, Maryland 20784							
20e. METHOD OF DISPOSITION 1 IX Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State							
4 Donellon 5 Other (Specify) MD State Veterans Cem. 4/14/95 Cheltenham, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE							
Francis Gasch's Sons Funeral Home, P.A.							
4739 Baltimore Ave., Hyattsville, MD 2078							
23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such se cerdiec or respiratory errest, ahock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final							
disease or condition resulting in dasth) a. Pulmonary Embolus							
DUE TO (OR AS A CONSEMBRING OF)							
Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
if any, leading to immediata cause. Enter UNDERLYING							
CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):							
resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PREPORMED? AMILABLE PRIOR TO AMILABLE PRIOR TO							
Chonic Obstructive Pulmonary Disease 1 yes 2 no OF CATHER							
1 VES 2 NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
EXAMINER? HOSPITAL: OTHER:							
1 YES 2 NO 1 Inpetient 2 ER/Oulpetient 3 DOA 1 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							
1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 286. DESCRIBE HOW INJURY OCCURED							
2 Accident 3 Suicide 286. PLACE OF INJURY — At home, form, street, factory, office 286. LOCATION (Street and Number or Rural Route Mumber)							
4 Homicide determined building, stc. (Specify)							
29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(s) end manner es stated.							
2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner as stated.							
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) April 12, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (TEM 27) (Typa, Print)							
Jenny May IMD 14333 Laurel Boure Rd #307 Laurel MD Z0708 31. DATE FILED (Morhit, Day, Year) 32. REGISTRAR'S SIGNATURE							
APR 13 1995 Julia Davidson Rayland							

												C	15	13560
	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAI	RTMENT	OF H	EALTH	AND I	MENTA		IENE		. 0000
	1. DECEDENT'S NAME (First	, Middle, Last)			<u> </u>	IOATE		DEA		2 DATE	REG.			3. TIME OF DEATH
	ANNA			ROSE			17.1	NO		MONT	Н	DAY	YEAR	C. Company of Landson
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		NG IF UNDER	24 HRS	APR 7 DATE	OF BIRTH	19,		THPLACE (State or Foreign
	21/ 05 /0	2.0	1 M 2 R F	()			YRS. MONTHS DAYS HOURS			(Mont	h, Day, Yea	1904	Cou	intry)
	214-05-48 9a. FACILITY NAME (# not #		street and number)	71		ab CITY	TOWN C	ID I OCATI	ON OF DE)			RYLAND
œ	SACRED HE		TO PAGE 1			100				EATH		9c. C	OUNTY OF	
5	RESIDENCE OF DEC		USPITAL		LU	MRE.	RLAN	(U				ALL.	EGANY	
DIRECTOR	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN	R LOCAT	101						10d. INSIDE CITY
5	MARYLAND	AL	LEGANY			LAV	ALE							1 X YES 2 NO
AL.	10e. STREET AND NUMBER						101	ZIP COD	E			10g. C	ITIZEN OF	WHAT COUNTRY?
FUNERAL	6 ROGER	WAY						2	2150	2			II C	
3	11. MARITAL STATUS		12. WAS DECEDER			13.	WAS DEC	ENDENT (OF HISPAN	NC ORIGI	17 (Specifi	y Yee or No-	U S	CE — American Indian,
	1 Never Married 2		FORCES?	MAR OR DATES	NO		If yes, sp	ecify Cuba	Specify	n, Puerto	Rican, atc	-)	Ble	ick, White, atc.
B	3 XWidowed 4 Divo	orced	1 120, 3112	out on parco			I [] IES	ZA NO	Specin	у.			Spe	ochy: WHITE
E	15. DEC	EDENT'S EDU y highest grade	CATION	16a. I	DECEDENT'S	USUAL O	CCUPATIO	ON .		168	. KIND OF	BUSINESS/	NDUSTRY	
Щ	Elementary/Secondary (College (1-4 or 5	+)	(Give kind of life. Do NOT u	se retired.)		ST OF WORK	ng					
Ē.	12			I	HOMEN	IAKE	R				OWN	MOH I	E	
COMPLET	17. FATHER'S NAME (First, M							18. MOT	HER'S NA	ME (First,	Middle, Ma	iden Surname)	
ш	JOHN D.	FARRE	LL					MAF	RYR	OSE	LLA	MCA	TEE	
TO B	19a, INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a	nd Numbe	or Rural F	Route Num	ber, City or	Town, State,	Zip Code)	
ř	ROBERT H.	KING		1	L5001	. NA	TIO	NAL	HWY	CU	MBER	RLAND	, MI	D 21502
	20a. METHOD OF DISPOSIT				EANDDATE		ITION (Na	ma o/		DAT	E 200	LOCATION	- City or	Town, State
	1 M Burtal 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) ST MARY CEMETERY APR 22 CUMBERLAND, MD													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	1 Jours	Xas	V H	ake										MORTUARY
-	1302 NATIONAL HWY LAVALE, MD 21502													
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate interval Between													
- 1	IMMEDIATE CAUSE (FIR	nal	-7) /	1.	-		. /	2	-	15			Onset and Desth
	disesse or condition resulting in death)	→	&	RMI	hat	son	-n	al	nu	In	ren	7		6day
			DUE TO	OR AS A CONS	EOUENCE O	F):		,	<					71
Z	Sequentially list condit	lone	a 13	one	L,	sey	no	12	m					1 de
Ĕ	If sny, leeding to imme	diate	OVETO	(OR AS A COMS	EOUENCE O	F):	, 7					, -		- /
2	cause. Enter UNDERLY		c U	rcu	non	1,/	ad	noy	17	nes	MIT	any	214	del 6 ms
RTIFICATION	that initiated events resulting in deeth) LAS		DUE TO	(OR AS A CONS	EQUENCE O	F):		,						
CEH			d											
	PART II. Other significa	int condition	ne contributing to	death but not	reaulting	In the un	deriving	Ceuse (alven in	Part I.	24a, WAS	S AN AUTOPS	y 24	ib. WERE AUTOPSY FINDINGS
MEDICAL	ASCIL	カー	1100	WI	-						PER	FORMED?	` °`	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	1		wo.	ny						-	1 🗌 YE	S 2 NO		DF DEATH?
Σ	DID TODACCO II	CE CONT	DIDLITE TO CA	LICE OF DE	ATI 1 1/1									1 TYES 2 NO
PHYSICIAN:	DID TOBACCO U		KIBUIE IO CA				10 K	UNC	ERTAIN	4 📙				
O O	EXAMINER?	O MEDICAL	HOSPITAL:	26. PL	ACE OF DEA	OTHER								
ΥS	1 TYES 2 NO		4	ER/Outpatlant	3 🗆 DOA			5 🗆 Re	eldence	6 🗆 Othe	r (Specify)			
품	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, E		28b. TIN	IE OF JURY	28c. INJI WO	JRY AT RK?		28d. DES	CRIBE HO	OW INJURY C	CCURED	
A		Investigation				M		ES 2 [NO					
		Could not be	28a. PLACE C building,	of INJURY — At I atc. (Specify)	home, term,	atreat, tacto	ory, office				ATION (Str or Town, S		er or Rural	Route Number,
E	- Intricioe	datarmined												
COMPLETED	29a. CERTIFIER (Check only	TIFYING PHYSI	CIAN: To the best of	my knowledge,	death occurr	ed at the ti	me, deta	and place	, and dua	to the cau	se(s) and	manner as s	tated.	
MO														(s) and manner as stated.
O	And Committees and the series	-								100000				

zouv 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 29c. LICENSE NUMBER 0

29d. DATE SIGNED (Month, Day, Year) APRIL 20, 1995

VICTOR MAZZOCCO, SETON DRIVE, CUMBERLAND, MD 21502 31. DATE FILED (Month, Day, Year)

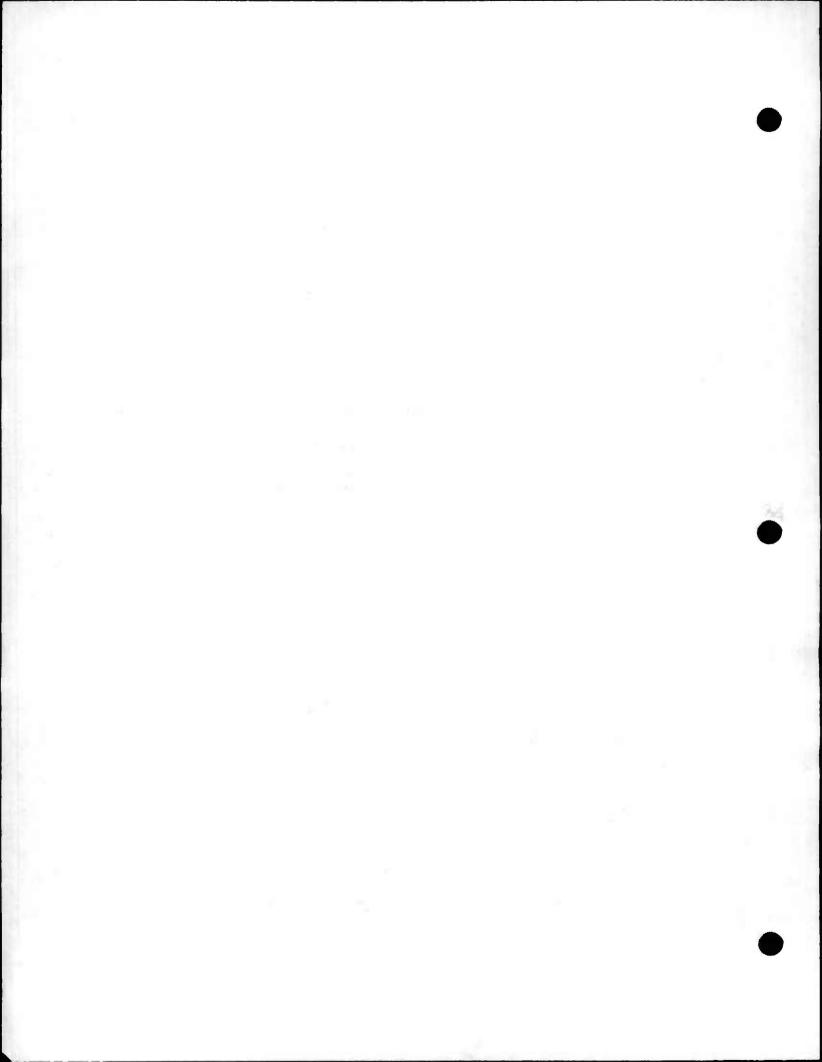
APR 2 1 1995

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3. TIME OF DEATH

A. M

12:45

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEKAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

COMPL

BE

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BALTIMORE, MARYLAND 21215-0020

DIRECTOR FUNERAL COMPLETED BE notified 2 9 must examiner medicai the event,

A

Pages 1, 2, 3 should

permit.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH April 19, KATHERINE C. KARLEM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 577-34-9648 1 - M 2 X F 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH Meridian Nursing Home Frederick RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Frederick Frederick 10e. STREET AND NUMBER 10f. ZIP CODE 618 Wilson Place 21702 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS If yes, specify Cuban, 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: 3 🔀 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION most of working College (1-4 or 5+) Elementary/Secondary (0-12) 10 17. FATHER'S NAME (First, Middle, Last) Peter Kuchesky Eva 19a. INFORMANT'S NAME (Type/Print) Catherine K. Graf 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Hagerstown Crematory

Attender The

ic

DUE TO (OR AS A CONSEQUENCE OF).

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign April 30, Pennsylvania 1897 9c. COUNTY OF DEATH Frederick 10d. INSIDE CITY LIMITS? 1 XYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, atc.) 14. RACE — American Indian, Black, White, atc. Specify: White 18b. KIND OF BUSINESS/INDUSTRY 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Murin 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Wilson Place Frederick, Maryland 21702 DATE 20c. LOCATION - City or Town, State 4/21/95 Hagerstown, Maryland 22. NAME AND ADDRESS OF FACILITYStauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD 23. PART I. Enter the diseases, or complications they caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate interval Between Onset and Deeth Lan 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TYES 2 NO OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

REG. NO

°×1995

YEAR

CERTIFICATION PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL Mothin's DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO OTHER:
4 Nursing Home 5 Assidence 8 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 3 Sulcida 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) ETED 8 Could not be 4 🔲 Homicide determined

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

296. SIGNATURE AND TIPLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

0-18191

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

187 Thomas Johnson Drive Frederick, Maryland Arthur G. Manalo, M.D.

32. REGISTRARIE SIGNATURE

31. DATE FILED (Month, Day, Year) 4-APR 25 1995

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

IMMEDIATE CAUSE (Fine)

Sequentially list conditions,

if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury

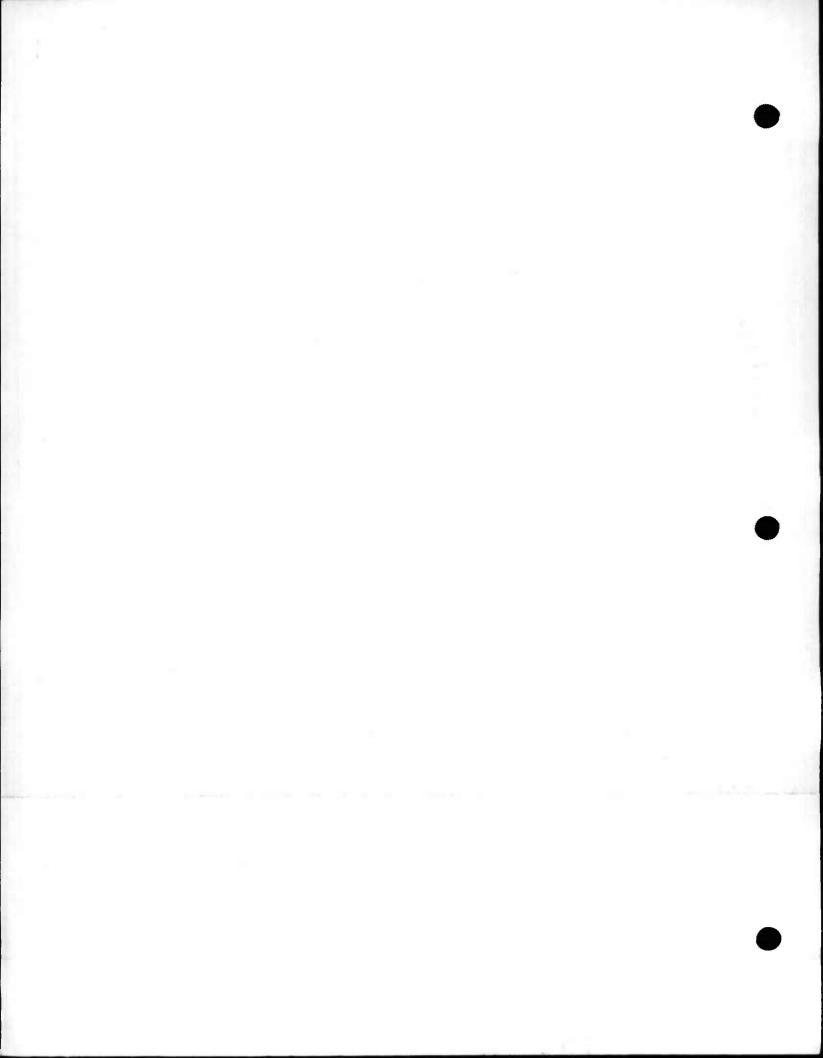
diseese or condition

reculting in deeth)

thet initiated events resulting in deeth) LAST

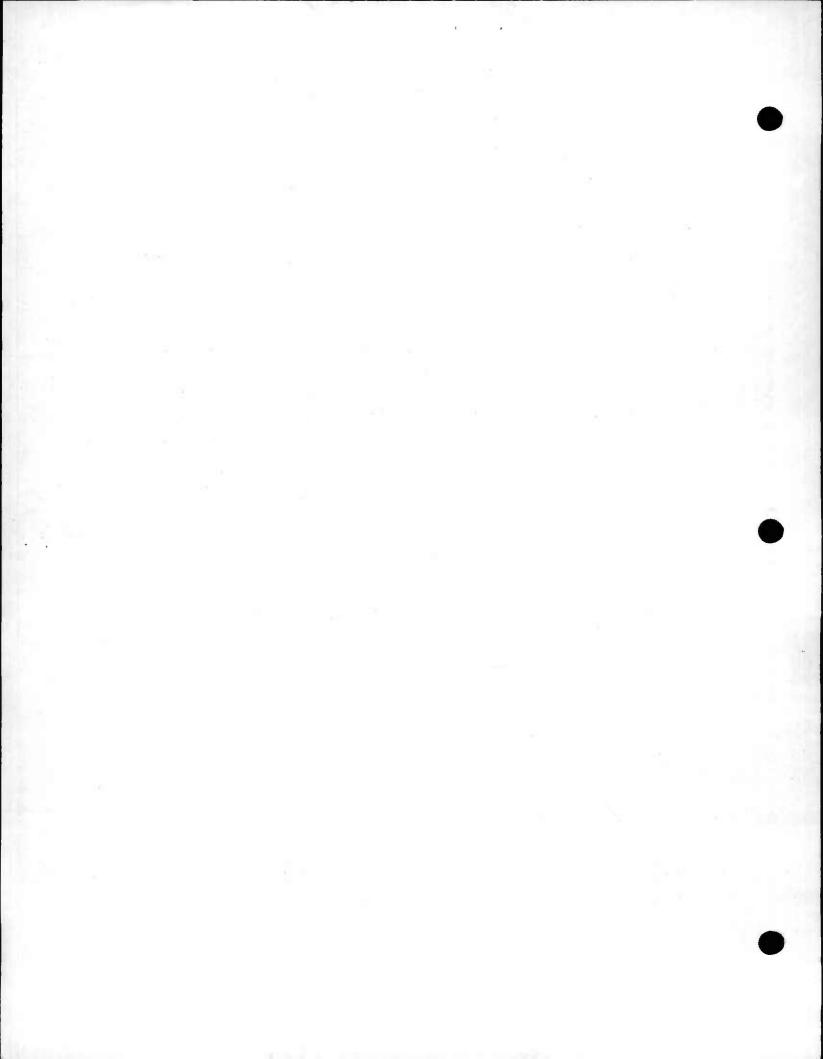
21702

4-19-5,

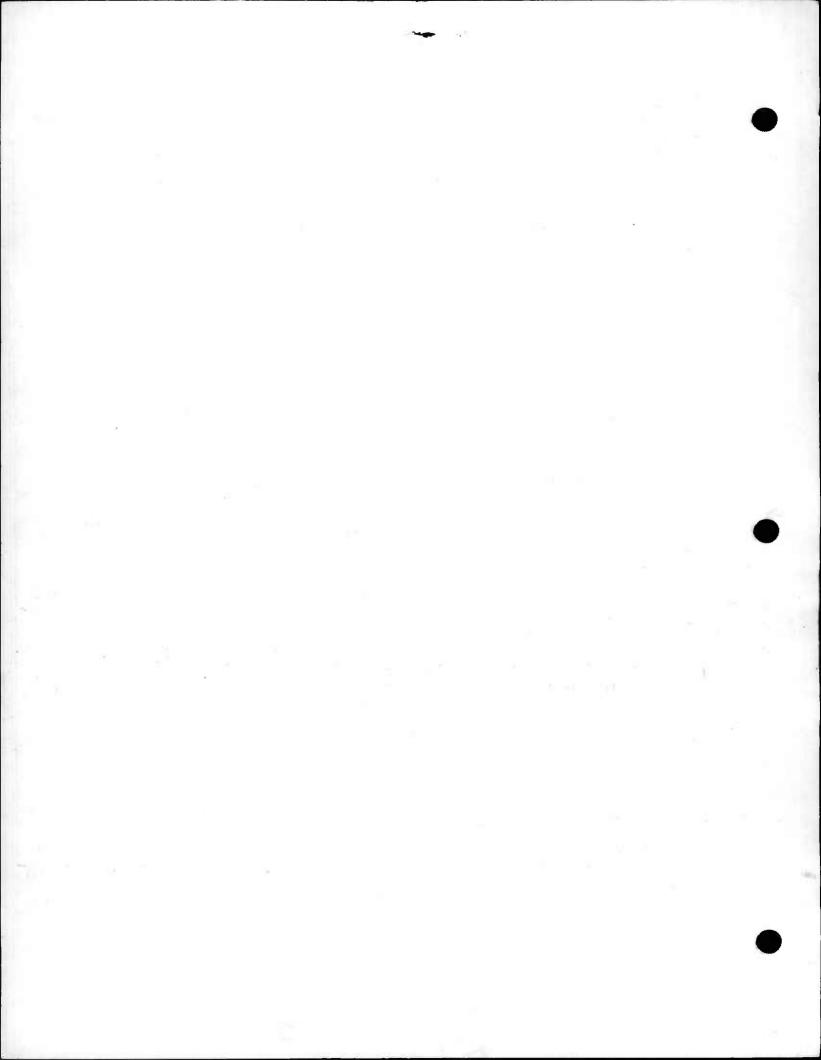


STATE OF MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	TH		REG. NO.

		1 - STATE OF MARYLAND / D REGISTRAR STATE OF MARYLAND / D	EPARTMENT OF HEALI	TH AND MENT	AL HYGIENE REG. NO.	,
		1. DECEDENT'S NAME (First, Middle, Last) Emily Kelton		2. DAT	TE OF DEATH	YEAR 3. TIME OF DEATH
				AF	oril 21 1	995 11:35 am
pin		4. SOCIAL SECURITY NUMBER 5. SEX 107 - 10 - 7674 9. FACILITY NAME (If not institution, give etreet and number)	YRS. MONTHS DAYS HOUR	MIN. Jun	ne 25,1897	8. BIRTHPLACE (State or Foreign Country) New York
1, 2, 3 should	TOR	North Arundel Hospital	Glen T	Burnia		ne Arundel
Pages	DIRECTOR		10c. CITY, TOWN OR LOCATION Albany			10d. INSIDE CITY LIMITS? 1 1 YES 2 NO
nsit permit.	ERAL	10. STREET AND NUMBER 37 Hawthorne Avenue	101. ZIP C 122		10g. CIT USA	IZEN OF WHAT COUNTRY?
-AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once.	FUN	11. MARITAL STATUS 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	0 13. WAS DECENDEN	NT OF HISPANIC ORIC	GIN? (Specify Yee or No-	14. RACE — American Indian, Black, White, etc.
21215-0020 If or attending physic for use as the burial	ED BY	3 N Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECE	DENT'S USUAL OCCUPATION	-	6b. KIND OF BUSINESS/IN	Specify: White
D 212	ᇤ	Elementary/Secondary (0-12) College (1-4 or 5 +)	kind of work done during most of wo	orking		
AND he hospit detached once.	COMPL	Grade 12 Hous 17. FATHER'S NAME (First, Middle, Lest)	sewife 16.M	OTHER'S NAME (First	Own Home	
18 E E	ш	John Beyer		hristine		
MARYLA retained by the 5 should be detected at one	0 8	19e. INFORMANT'S NAME (Type/Print) 19b. 1	AAILING ADDRESS (Street and Nurr	mber or Rural Floute Nu	imber, City or Town, State, Zij	p Code)
age age			Beech Grove		7	
Page 6 mar al director, p		200.FLACE ANI	tory or other place) Hill Cemetery			New York
ALTIMO death. Page 6 tuneral directo		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADD	DRESS OF FACILITY		
BALTIN BALTIN ter death. Pag the funeral di val.		· Whitten Solle			al Home, P.A	A. aryland 20707
ted within 24 hours after completely filled in by the ial, cremation, or removal.		23. PART i. Enter the disease, of complications that caused the deat ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUE		dying, such aa ca	ardiec or respiratory ar	Approximate Interval Between Onset and Death
h certificate be executed by the certificate be executed by the certificate by the certif	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE CO.				
at the death by the atternal Mental	AL C	PART II. Other significent conditions contributing to death but not ree	alting in the underlying ceus	se given in Part i.	24a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINOINGS
ATENDING PHYSICIAN: The law requires that the ECTOR. After this certificate has been signed by the staffer death with the State Dept. of Health and n 28 is marked, or item 23 shows any in	MEDICA				PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
taw relas beer of 23 sh	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES NO U	NCERTAIN		
N: The higher than State D	200	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO 20 Inpatient 2 ER/Outpatient 3	OF DEATH (Check only one) OTHER:			
NG PHYSICIA frer this certification with the marked, or	PH	27. MANNER OF OEATH 1 Natural 5 Pending 28s. OATE OF INJURY (Month, Day, Year)	Bb. TIME OF Sc. INJURY AT WORK? M 1 YES 2	7 26d. D	ESCRIBE HOW INJURY OC	CURED
OR ATTENDING DIRECTOR: Atten hours after deat	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home building, etc. (Specify)		261. LC	OCATION (Street and Number by or Town, State)	r or Rural Route Number,
TAL OR TAL DIR 72 hour	MPLETE	29a. CERTIFIER (Check only one) 2 MEGICAL EXAMINES: On the best of my knowledge, death one)				
TO THE HOSPITAL TO THE FUNERAL Se filed within 72 is IMPORTANT: If I	E C0	2 MEDICAL EXAMINER: On the beele of examination end/or inverse. 29b. SIGNATURE AND TITLE OF CERTIFIER		LICENSE NUMBER		
TO THE HOSPI TO THE FUNE BE filed within IMPORTANT:	TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2	CEP. D	43977	- Pa	E SIGNED (Month, Day, Year) 2111 195
		Myoken DIETENST. North Amorbel Ho	2p. 301 Hosp. 1	SR. Gran	Burne 1	us.
15		31. DATE FILED (Month, Day, 1681) APR 2 7 1995 32. REGISTRAR'S SIGNATURE	1			
		ALL NI IVO				



		1 - FOR STATE REGISTRAR	TE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND		YGIENE EG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) PATRICIA		TTO			2. DATE OF D	EATN DAY	95 3.	TIME OF DEATH
P		0,0 0025 =	M 2 1 6	n yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BUILDING Month, Day, June 2:	RTH Year)		ACE (State or Foreign
2, 3 should	TOR	99. FACILITY NAME (If not institution, give street and HOWARD COUNTY General RESIDENCE OF DECEMENT	-	1	96. CITY, TOWN COlumb	or location of D	DEATH	9c. COUP HOW	NTY OF DEAT	
permit. Pages 1,	DIRECTOR	100. STATE 100. COUNTY Maryland Howard			Y, TOWN OR LOCAL					Dd. INSIDE CITY LIMITS? X YES 2 NO
- [5	FUNERAL	100. STREET AND NUMBER 3112 Wheaton Way Ap	t H		10	1. ZIP CODE 21043		10g. CITI	ZEN OF WHA	AT COUNTRY?
215-0020 attending physician. se as the burlal-transit	BY FUN	11. MARITAL STATUS 12. WA	S DECEDENT EVER IN RCES? 1 TYES YES, GIVE WAR OR DA	2 X NO	13. WAS DEC	CENDENT OF NISPA secify Cuben, Mexic 2 NO Spec	an, Puerto Rican,	ecify Yes or No-	14. RACE — Black, W Specify:	American Indian, Vhite, etc.
			ge (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION work done during mose retired.)	ON ost of working	16b. KIND	OF BUSINESS/IND		nite
LAND 21 the hospital or e detached for u	COMPLETED	17. FATNER'S NAME (First, Middle, Last)	ears	Claims	Represe	18. MOTNER'S N	AME (First, Middle	urance		· · · · · · · · · · · · · · · · · · ·
MARYL retained by 5 should be notified at) BE	Robert Rushford 190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		a Hanna Route Number, Ch	n ty or Town, State, Zip	Code)	
P age a	5	Dave Knott	T anh	23049	Clevela	nd, Dear	born, M	ichigan (48124	
MOR ge 6 mg lirector,		1 □ Burlei 2 □ Cremation 3 ☑ Removal from 4 □ Donation 6 □ Other (Specify)	m State Ceme	etery, cremetory or of the Hedw.	of disposition (Na ther place) ig Cemet	ery	4/26	20c. LOCATION — (Dearborn		
BALTIMORE, hours after death. Page 6 may be od in by the funeral director, page or ennoval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Oul!		Donald 313 Ta	albott A	eral Ho ve. Lau	me, P.A. rel, Mar	vland	
tely fille		23. PART I. Enter the diseases, or complic shock, or heart failure. List only IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ations that caused by one cause on ea	the death. Do inch line.	TARCT	de of dying, su	ch se cerdisc d	or respiratory arre	est,	Approximate intervel Batween Onsat and Death
68760 executed withing and completely o burial, cremat matic event, it	NO	Sequentially list conditions,	DUE TO (OR AS A	MSIAN)м	ITRAL VAL	VULAR STE	NOSIS		YEARS
P.O. BOX h certificate be anding physician Hygiene prior to or other traur	CERTIFICATION	If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	3 MA	LIPUS-	HYPERTI	ENSION			YEARS
TAL RECORDS The law requires that the d te has been signed by the ate Dept. of Health and Me am 23 shows any injur	: MEDICAL	PART II. Other significant conditions control in the property of the property	LOWER LOBES TO CAUSE OF	GIGMOID CO ," MILD C DEATH YE	LON", "ACU ORONARY AI S X NO L IN (Check only one)	TE BRONCHO	DSIS".	WAS AN AUTOPSY PERFORMED? YES 2 NO	CO OF	PERE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
OF VI HYSICIAN: his certifica with the Sta	PHYSICIAN	1 YES 2 NO 1 In	patient 2 - ER/Outpe	28b. TIM	E OF 28c. INJ	e 5 Residence		cify) E NOW INJURY OCC	UBED	
S at the	À	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 28	(Month, Day, Year)	— At home, farm,	M 1 1	PRK? YES 2 NO		(Street and Number		Number
DIVISIO OR ATTENDIN DIRECTOR: An hours after de:	ETED	4 Nomicide determined	building, etc. (Specif	(y)			City or Tow	n, State)		7 7000000
7 72 4	COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the								d mannar ee stated.
TO THE HOSPITA TO THE FUNERA Be filed within 7 IMPORTANT: 1	TO BE	30, NAME AND ADDRESS OF PERSON WHO COMPL	ETED CALLOS OF DEA			29c. LICENSE NU	296	> /-	PRIL	onth, Day, Year) - 21, 1995
		JOSEPH IT GIBBONS, 1	MD 950	11 och	ANNAPOL	US RD,	ELLICO	TT CITY	M	21042
15			in danwelson							



BALTIMORE, MARYLAND 21215-0020	irs after death. Page 6 may be retained by the hospital or attending physician.	I hav the funeral director name 5 chould be detached for use on the business
	4 hour	filled in
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been stoned by the attending obvision and completely filled in by the funeral director made 5 should be described for use as the business

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certiin THE FINERAL DIRECTION. After this certificate has been closed by the attendent

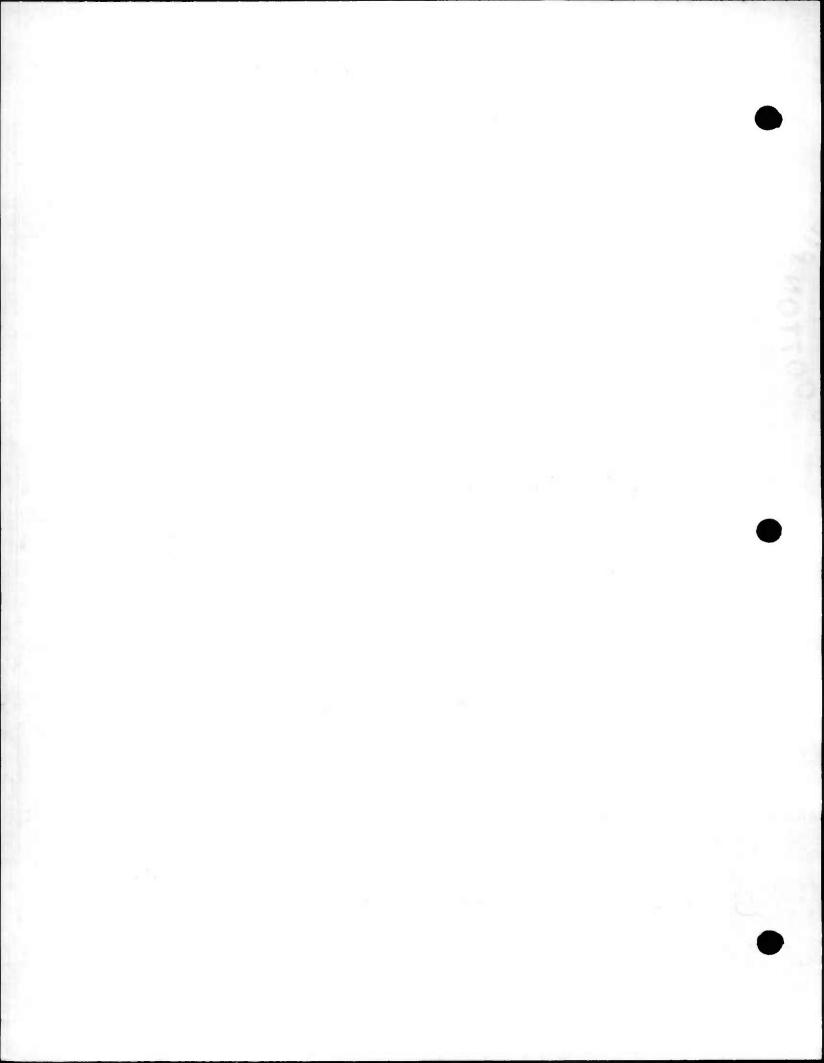
		FOR 1 - STATE		STATE OF A	WARYLAI						MENTA	L HYGIEN	E E))	13364
		REGISTRAR 1. DECEDENT'S NAME (First,	Middle Last)		7-	CERT	IFICA	TE OF	DEAT	ГН	- CATE	REG. NO.			
		ROBE		L	12		K	valt	-		MONT	H DA	199	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In	yrs. lest birtho		NDER 1 YEAR	IF UNDER		7. DATE	OF BIRTH			IPLACE (State or Foreign
<u>p</u>		183-14-83		1 M 2 🗆 F	71	YR	IS. MONT	THE DAYS	HOURS	MIN.		r. 6	1924	Penn	, sylvania
nous	ac	90. FACILITY NAME (If not ins					9b. 0	CITY, TOWN O			ATH			NTY OF D	
, 2,	DIRECTOR	PENINSULA R	EGION	AL MEDICA	L CEN	ITER		SALIS	SBURY	<u> </u>			W1	COMI	CO
office office	REC	10e. STATE	10b. COUNTY	٧				WN OR LOCAT							10d. INSIDE CITY LIMITS?
periint, rayes 1, 2, 3 shound		Maryland 100. STREET AND NUMBER	Some	rset		P	rinc	ess Ar							1 - YES 2 X NO
5	BA	13308 Pine	Reach	Road				101.	218 218	_			10g. CITI		WHAT COUNTRY?
100000000000000000000000000000000000000	FUNERAL	11. MARITAL STATUS		12. WAS DECEOEN	T EYER IN U	S. ARMEO		13. WAS DEC	ENDENT O	F HISPANI	IC ORIGI	N? (Specify Yae	or No-	U.	- American Indian
	BY F	1 Never Married 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		12. WAS DECEOEN FORCES? 1 IF YES, GIVE V		2 NO		If yes, spe	2 NO	n, Mexicen	i, Puerlo	Ricen, atc.)		Black Specif	c, White, etc.
			EDENT'S EDU	CATION WW		en DECEDER	TTO LIGHA	AL OCCUPATIO			1 400				White
9	ETE	(Specify only Elementary/Secondary (0-	r highest grade	College (1-4 or 5		(Give kind	of work do	lone during mos ed.)	st of workin	g	101	. KINO OF BUS	INESS/INC	USTRY	
	COMPLETED	12		2	"	Marin	ne Po	olicem	ian		5	State o	f Ma	ryla	nd
at once.		17. FATHER'S NAME (First, Mid		0								Middle, Maiden			
e pei	H	Ralph L. Ki		Sr.		T 405 MAII	THE ADDE					Harbo			
notified	임	Barbara Park		l								incess			d. 21853
2		30 METHOO OF DISPOSITION Burlant 2 Crempatition			20b. Pl	LACE AND DA	ATE OF DISI	POSITION (Na		Noad	, FI		CATION —		
E L	10	4 Donation 5 Dotter	(Specify)		- Ast	ory, crematory	_					22 Mt.			
examiner must		21. SIGNATURE OF FUNERAL	SERVICE LIC	ABOSEE .				22. NAME AN	Man I	S OF FAC	HLITY				
val.		James	00	Hana				Pri	nces	s Anr	ne.	Md. 21	853		
or removal.			eert reliure.	complications that List only one cau	t caused thuse on eacl	he death. D h iine.	o not en					diec or reapi	ratory arr	eat,	Approximate interval Between
the i		/IMMEDIATE CAUSE (Fine	ei		Car	dia	-1	a	res	动,					Onset and Death
Mental Hygiene prior to burial, cremation, jury, or other traumatic event, the		resulting in death)	7	DUE TO	(OR AS A CO	ONSEQUENC	E OF):		10	N N	1		7		1/2 hr
giene prior to burial, cremation, other traumatic event, the	N	Sequentially list condition	A70	a Phe	sun	red	my	olans	dal	2 4	DA	nch			'
ior to	ATIC	If any, leeding to immed cause. Enter UNDERLYIN	diate	DUE TO	(OR AS A CO	ONSEQUENC	E OF):				0				
ther t	FIC	CAUSE (Disease or Injur		c. DUE TO	(OR AS A CO	ONSEQUENC	E OF):								
or ot	CERTIFICATION	resulting in deeth) LAST	r [d											
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State Dept. of Health and Item 23 shows any It	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?) MEDICAL	HOSPITAL:		PLACE OF D	ОТН	eck only one)							
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death with	> 1	1 Netural 5 🗆 P	Pending	(Month, D		200.	INJURY M	28c. INJL WOF II 1 Y	URY AT PIK? (ES 2	123	26d. UE:	SCRIBE HOW IN	JURY OCC	URED	
0 40	D B	3 Deutalda	nvestigation Could not be	28e. PLACE O	F INJURY — atc. (Specify)	At home, tar	m, street,				261. LOC	ATION (Street e.	nd Number	or Rural A	oute Number,
rs after m 28 is	ETE		determined		alle (Oproving)						Спу	or Town, State)			
72 hours If item	교			CIAN: To the best of											
ANT:	COM				ramination er	nd/or investig	pation, in m	πy opinion, de	eth occure	ad at the ti	lme, data	end plece, end	due to the	a cause(e)	end menner ee stated.
be filed within 7	BE (29b. SIGNATURE AND TITLE	OF CERTIFIER	Hoa			N	12	29c. LICE	NSE NUME	BER C	9	29d. DATE	SIGNED	(Mogth, Day, Year)
M Pe	5	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CALE	DE DE DEATH	1 STEM 27) (J Prints		U.	271	11		1	1-1	17
		CHAIRS STEE	MAN,	no.	3043	of M.		ERNON	' ND		PKI	W1835	AHLE	5, n.	20
		APR 2 0 1995	Julia Julia	32. HEGISTRA	S SIGNATU	IRE									

Alex specific diagram page (page)

amended #2, 4/12/95, M. R. S. allegary County 95 13565

1 - STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR				CERTIF	ICATE	OF	DEATH		REG. N	Ю			
		1. DECEDENT'S NAME (First, JAMES	Middle, Last)	TEDOV		_				2. DAT MON	E OF DEATH	DAY	YEAR	3. TIME OF D	EATH
		4. SOCIAL SECURITY NUMBER	-	LEROY 5. SEX			ASMIE		1	_		1995	_	0455	A M
		235-54-8252	EM	5. SEX 1 M 2 F	6. AGE (In yrs	t. last birthday) YRS.	IF UNDER 1	DAYS	HOURS MIN.	(Mor	E OF BIRTH oth, Day, Year)		Country	PLACE (State or	Foreign
pino		9a. FACILITY NAME (If not ins	titution olim a		- 60	rns.	41 4171				y 16		WV		
3 should	œ	Sacred Heart		77.					rland	EATN		9c. COUN			
1, 2,	CTOR	RESIDENCE OF DEC		Jitai			Cu	шре	ELIANU			Alle	gany		
Sees	DIREC	10a. STATE	10b. COUNT			10c. CIT	Y, TOWN OR	LOCAT	ION					10d. INSIDE C	ITY
permit. Pages		MD	A	llegany		_	McCoc	1e					_ 1	LIMITS?	NO NO
	AL	10s. STREET AND NUMBER						101.	. ZIP CODE			10g. CITIZ	EN OF WI	HAT COUNTRY	7
physician. burial-transit	FUNERAL	75 Queen Sti	reet						21562			υ.	S.A.		
ysicia rial-tr		11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED XNO			ENDENT OF NISPAN			Yea or No-	4. RACE	- American Ir White, atc.	ndlan,
3-0020 nding physic as the burial	BY	1 Never Married 2 🖔 R 3 Widowed 4 Divort		IF YES, GIVE WA			1 (YES	2 NO Specifi	y:	rican, and.)		Specify	r:	
as t	ED		DENT'S EDU	CATION	100	DECEDENTIA	1			_			Whi	te	
or atte		(Specify only	highest grade	completed)	108	Give kind of We. Do NOT u	work done du se retired.)	ring mos	on st of working	16	b. KIND OF 8	JUSINESS/INDU	STRY		
ed pital of	COMPLET	Elementary/Secondary (0-	12)	College (1-4 or 5+)	Т	ruck I				C	oncret	e Manu	fact	turing	
the hospit detached	S S	17. FATHER'S NAME (First, Mic	idle, Last)			I den z	711701		18. MOTHER'S NA					. 01 1116	
8 a a	ШС	Franklin H	Rudo1r	h Kasmie	r				Viola	Sus		Smiley			
retained by 5 should b		19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	Street a	nd Number or Rural I				odel.		
(I) as	임	Edna B. Kası	nier				ieen S				e, MD	21562			
page be		200. METHOD OF DISPOSITIO			20b. PLA	CE AND DATE				DA		LOCATION - C		n State	_
DAL IIMORE, MAR safer death. Page 6 may be retained in by the funeral director, page 5 should removal.		1 Burlal 2 □ Cremation 4 □ Donation 5 □ Other (ovel from State	cemetery	cremetory or a	ther place!		Gardens 4	ł		eyser,		26726	
Pag Finer		21. SIGNATURE OF FUNERAL	SERVICE LIC	EN9EE			22. N/	AME AN	ID ADDRESS OF FA	CILITY					
after death. Pag y the funeral di moval.		▶ / (/ a.	1						k-Smith					0670	,
y the	\vdash	23. PART I. Enter the dis	2000 00	Complications that	named the	death De	[85	Sou	th Main	Str	eet l	Keyser,	WV	2672	
24 hours after filled in by th ion, or remove the medical		snock, or ner	acrienure.	List only one gaus	on each	line.	iot enter tr	ie mod	de or dying, such	n as cei	rdiec or ree	piratory arre	et,	Approxi	mate Between
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completely fille rial, cremation,		resulting in deeth)	*	a.C/MSY	HAS A COL	ISEOUENCE O	HSTH	TIC	140101	OCF	KIIn	DOA	0	2	YR5
2 5 - 0	_			-52 10 (71 72 A CON	ISCOULNCE U	r).			f	PROS	una tate			/
ertificate be executing physician and cigiene prior to burian other traumatic	ERTIFICATION	Sequentially list condition if any, leading to immediate		DUE TO (C	R AS A CON	ISEQUENCE O	F):							-	
teath certificate be evattending physician a attending physician and Hygiene prior to y, or other traum	§	cause. Enter UNDERLYIN	IG												
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th c	ᇤ	resulting in desth) LAST		d											
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uires tha signed Health a											1 TYES	2 2.40		CDMPLETION O OF DEATH?	F CAUSE
	Σ	DID TOPACCO LIC	T CONITI	NIDUITE TO CALL	CE OF D	EATH >//								1 TYES 2] NO
law Dept 23	AN	DID TOBACCO US 25. WAS CASE REFERRED TO		KIBUIE IO CAU		LACE OF DEA			UNCERTAIN	<u>и П</u>					
E 3 5 E	SICIAN:	EXAMINER?	LUICAL	HOSPHAL:			OTHER:								
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The sit is	Y P	1 Nortiral 5 A		(Month, Day,	Year)		URY	WOI		200. DE	SCHIBE HON	INJUNI OCCU	HED		
NDING I: After r death is man	9 0	a D a tit	ould not be	28e. PLACE OF	INJURY — At	t home, farm, a			- 50	281, LO	CATION (Stree	t and Number o	Rural Ro	ute Number	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	Ш		termined	building, at	c. (Specify)					City	or Town, Stat	(0)	110.0.710	are removi,	
OR A DIREC hours	COMPLE	29a. CERTIFIER	FYING PNYSI	CIAN: To the best of m	v knowledne	death conve	and set that there			1-30					
ははなり	M			R: On the basis of exa										and manage	atatud
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		29b. SIGNATURE AND TITLE C	-												
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT:	98		11/1	1/san	IN	M		- 1	29c. LICENSE NUM	I X	' /			Month, Day, Yea	95
₽ ₽ ₽ 3 3	일	30. NAME AND ADDRESS OF I	PERSON WH	COMPLETED CAUSE	OF DEATH	ITEM 27) /Time	Print)			. 1 0	1	APR	тг б	>17	13
\leq		DR. GARY WAG		//				ROAT). CIIMREI	RT.AN	п. мп	21502			
		31. DATE FILE PRY, 1 01/2	ar)	62 REGISTRAR			won I	CVANL	, JOHN 11	- THIN	υ, III	21302			
		MFK I 2	1992	1 1000	Horna	Actually									
										_					



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with nouns after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First,	, Middle, Last)									2. DATE OF	DEATH			3. TIME OF DEATH
	Olive	er Lec	rates								April	D		95	1000 0000
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE	(In yrs. las	t birthday)	IF UNDER	1 YEA	R IF UND	R 24 HRS.	7. DATE OF	BIRTH		~ ~	12:55 pm M HPLACE (State or Foreign
	218-34-983	3	1 X M 2 F	81		YRS.	MONTHS	DAY	B HOURS	MIN.	(Month, I	-1913	3	Md.	(vv)
ב	9e. FACILITY NAME (II not in Deer's He	ead Ce	enter	01	ģ.				N OR LOCA	TION OF D		171.	9c. COL	omi	DEATH
DINECTOR	RESIDENCE OF DEC								-						
	10a. STATE	10b. COUNTY					Y, TOWN		CATION						10d. INSIDE CITY LIMITS?
i	Md.	Wic	omico			De	lmar								1 TES 2 NO
ONE LIVE	10e. STREET AND NUMBER								10f. ZIP CO						WHAT COUNTRY?
	30595 Gord	y Mill						丄	2187				USA	1	
5	11. MARITAL STATUS 1 Never Married 2 💢 3 Widowed 4 Divo		12. WAS DECEDED FORCES? IF YES, GIVE	YES	2 X N	MED IO		If yes,	ECENDENT specify Cul ES 2 X N	en, Mexic	NIC ORIGIN? (an, Puerto Ric fy:	(Specify Yer an, etc.)	or No-	Blac	E — American Indian, ik, Whita, atc. White
3	15. DEC	EDENT'S EDUC	CATION		16a. DE	CEDENT'S	USUAL O	CCUP/	ATION		16b. K	IND OF BU	SINESS/IN		
ان	Elementary/Secondary (0	y highest grade	College (1-4 or 5	+)	(Gi	Do NOT us	work done se retired.)	during	most of work	ing					
1	6	,		,		Farm	er				Gr	ain 8	. Veg	etab	les
COMPLETIES	17. FATHER'S NAME (First, M	liddle, Last)				***			18. MO	THER'S NA	AME (First, Mic	_	_		
	Rola J. Le	cates							Vi	rtie	Ellio	tt Le	cate	s	
	19a. INFORMANT'S NAME (7	Type/Print)			191	b. MAILING	ADDRES	S (Stree			Route Number				_
2	Lois R. Tw	illev									, Delm				
				201	PLACE	NDDATE		_		toda	DATE	_			own, Stata
ı	20a, METHOD OF DISPOSIT 1 Neurial 2 Crematio 4 Donation 5 Other	n 3 Remo	oval from Stata							rdone	4-13	Hol	oron,		
	21. SIGNATURE OF FUNERA		ENSEE 1/1		PLIL	SHIII	22	NAME	AND ADDR	ESS OF F	ICII ITY			Mu	·
	~ 11	- M4	1//7	-/			S	hoi	rt Fu	nera	l Home	, Ind	· .		
	23. PART i. Entar the d	nIn	AKON	K							St. De				940
	Sequentially list condit if any, laading to imme- cause. Enter UNDERLY CAUSE (Disease or Inju- that initiated events resulting in death) LAS	diate ING iry	Syste	emic (or as /	2 lu A CONSEC	DUENCE O	ery				fa	ilur	e	ilea	rt5 years
	PART II. Other algorifica Hypertens		a contributing to	death b	out not r	esulting	In the u	nderly	ring cause	given in	2.5	4a. WAS AN PERFOR	RMED?	241	D. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL						26.	PLACE OF	DEATH (C/	neck only one)				
	1 YES 2X NO		HOSPITAL:	ER/Out	patient 3	□ DOA	OTHE		lome 5 🗆 l	Rasidenca	8 Other (Specify)			
.		Pending Investigation	28a. DATE Of (Month, L			28b. TIM		26c.	INJURY AT WORK? YES 2		28d. DESCI		NJURY OC	CCURED	
	3 Suicide 8	Could not be determined	28a. PLACE (building	OF INJURY atc. (Spe	f — At ho	me, ferm, :	street, fac	tory, o	ffica			ION (Street Town, State)		r or Rural	Route Number,
			CIAN: To the best o												a) and manner as stated.
	296. SIGNATURE AND TITLE	Shre	ettia	M	D					278	MBER		29d. DAT	TE SIGNE	0 (Month, Day, Year)
		stha,	M.D.,	Dee	r's	и 27) (Туре, Неа	Print)	en			О. В	ox 2	018	, Sa	lisbury,M
	31. DATE FILED (Month, Day, APR 1	^{yoar)} 4 1995	32. REGISTR			dall									
			U												DHMH-16 Ray 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

GREGO

5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

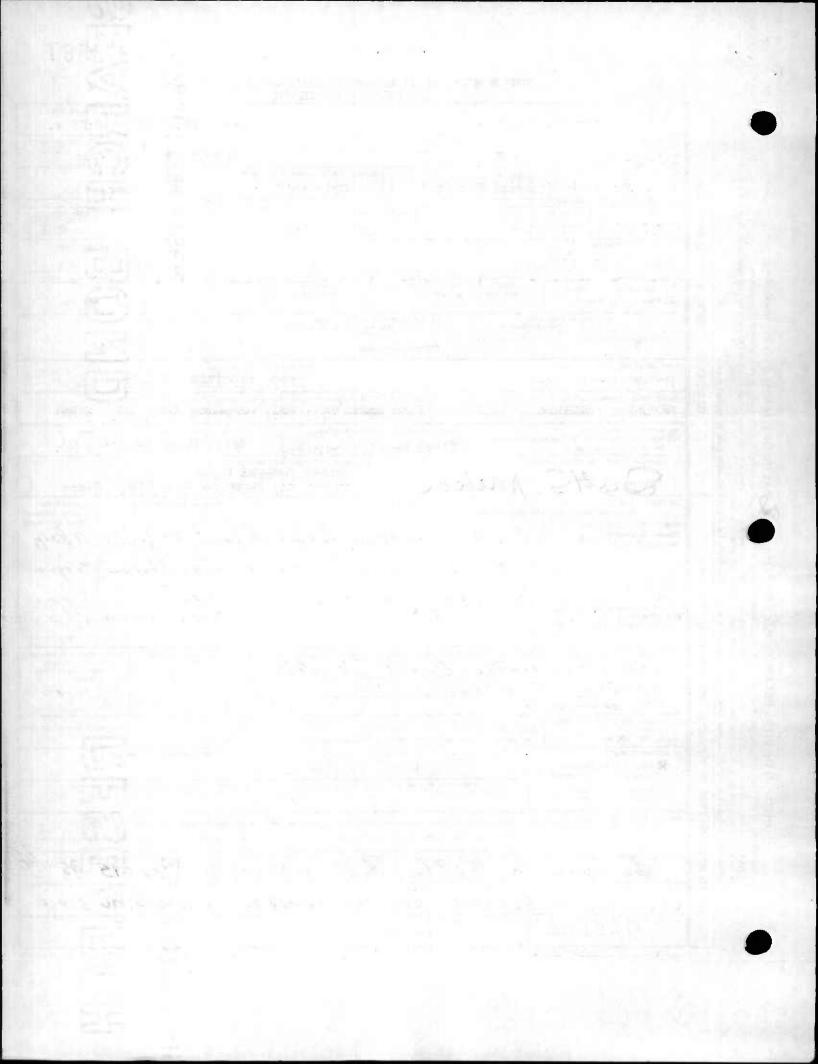
1	1. DECEDENT'S NAME (First		Linton							2. DA	TE OF DEA	TH DAY	100	YEAR	1000	OF DEATH	
1	4. SOCIAL SECURITY NUM	2	Linton		for a bit about			I		-			199	_		5 a.	M
	213-05-1963	3	1 M 2 X F	6. AGE (in yr.	97 YRS	MONTHE	DAYS	HOURS	MIN.	(Mc	E OF BIRT 10th, Day, Y	ear)	7	Count	HPLACE (SI 179) Vland	tate or Foreig	'n
	Edw.W.McCre	eady M		lospita	1	9b. CIT		sfiel		EATH				Some:			
	Maryland	Worce			10c. 0	DOGO:		City							LIMI	IDE CITY	
-	10a, STREET AND NUMBER		DOCE			FUCU		1. ZIP CODE			_	-	10a CIT	IZEN OF	WHAT COU	-	_
	1830 Cedar	H=11	Pond									- 17	log. on		W. I.A. 500		
1	11. MARITAL STATUS	патт	12. WAS DECEDEN	IT EVER IN U.S	ARMED	1 12		21851 CENDENT O	E HICDAI	NIC OBY	NAS /Poss	the Man o	w Ma	USA	E Amada	can Indian,	_
	1 Never Married 2 3 Widowed 4 Div		FORCES?	YES 2	NO		If yes, sp	ecity Cuba 2 2 NO	n, Mexica	nn, Puerl			# NO _	Bled	k, White, a	tc.	
1	15. DEC	CEDENT'S EDU	CATION	16a	. DECEDENT	T'S USUAL O	OCCUPATI	ON		T	6b. KIND (OF BUSIN	NESS/INI	DUSTRY	77111		
	(Specify on Elementary/Secondary (nly highest grade (0-12)	College (1-4 or 5	,	(Give kind life. Do NOT eamst	of work done use retired.	e during mo)	ost of workin	9								
	17. FATHER'S NAME (First, A	Middle, Last)						18. MOTH	IER'S NA	ME (Firs	t, Middle, A	felden St	urname)				
ı	Henry Fra	nk Ad	ams					Ma	ry	Vir	gini	a s	Ster	cline	or .		
1	19a. INFORMANT'S NAME (-		19b. MAILI	NG ADDRES	SS (Street										
H	Margaret B	uchana	n		1826	Ceda	ar Ha	all R	d.,	Poc	omok	e C	itv	Md.	. 21	851	
	20a. METHOD OF DISPOSIT	TION								-							-
1	1 N Buriel 2 ☐ Crematic	ion 3 🗆 Rem	ioval from State	cametary	crematory of	or other place	9)			1					own, State	Md	
H	1 N Burlel 2 Crematic 4 Donation 5 Othe 21. SIGNATURE OF FUNERA	on 3 Rem or (Specify)		cametary		or other place Dtist	cer			4/					ity,	Md.	
	4 Donation 5 Other	on 3 Rem or (Specify)		cametary	, crematory o	or other place Dtist	Cen NAME A	neter	s of fa	4/ ciuty cal	18 Home	Poc	omok	ce Ci	ity,		
	21. SIGNATURE OF FUNERA 23. PART I. Enter the c	on 3 Remote (Specify) AL SERVICE LI Classes, Dr	CENSEE Compileations the	cametary Fir	st Ba	ptist	Mels PO F	neter ND ADDRES SON F	uner 4, F	4/ cal coco	18 Home moke	Poco	omok	md.	218	51 proximats	
	21. SIGNATURE OF FUNERAL 23. PART I. Enter the cahock, or fi	AL SERVICE LI diseases, Dr heert fallure.	CENSEE	cametary Fir	st Ba	ptist 22 not ente	Cen R. NAME A Mels PO F	neter ND ADDRES SON F BOX 6- Dode of dyl	uner 4, F	A/ACILITY Call	Home moke profes or	Cit reapira	ty,	Md.	218 Applinte	51	V00
	23. PART I. Enter the cahock, or h IMMEDIATE CAUSE (FI disease or condition resulting in death) Sequentially list condition, leading to immediate. Enter UNDERLY CAUSE (Disease or injuttat initiated events	AL SERVICE LI AL SERVICE LI Also and a service Li Also and a serv	complications the List only one can be as a complete to the co	cametary Fir	a death. Di	prother place ptist 22 p not enter (e) (e) (i) (ii) (iii)	Cen R. NAME A Mels PO F	neter ND ADDRES SON F BOX 6- ode of dyl	uner 4, F	A/ACILITY Call	Home moke profes or	Cit reapira	ty,	Md.	218 Applinte	51 proximats erval Betw	V00
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	23. PART i. Enter the cahock, or himmediate cause. Enter UNDERLY PART ii. Other signification in the cause. Enter UNDERLY PART ii. Other signification in the cause. Enter Underly PART ii. Other signification in the cause. Enter Underly PART ii. Other signification in the cause. Enter Underly 25. Was case reference to examine resulting in death) 26. Was case reference to examine resulting in death of the cause of	AL SERVICE LI AL SERVICE LI Consumer (specify) AL SERVICE LI College (CENSEE Compilications the List only one case a. C. V. Due To b. Due To c. Due To d. D	cametan Fir	a death. Drilline. St Ba a death. Drilline. Sheduence Cychence One resultin	or other place ptist 22 22 22 22 22 22 22 22 22 22 22 22 22	26. PLER: Ursing Hon	neter ne	Ing, suc	A/ACILITY Call. POCCO This school Part I.	Home moke erdiec pr	Cit reapira	omole ty, intry are the ty of the ty	Md. rest.	218 Applinte On G S b. WERE AU AVAILABL COMPLET OF DEATH	proximate erval Betweet and D P day Topsy Finding Topsy Finding Topon To Topon Or Caustin 17	vee leat
	23. PART I. Enter the cahock, or himmediate condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) ACAUSE (Disease or injuried that initiated events resulting in death) LAS PART II. Other signification of the cause of the	AL SERVICE LI AL SER	CENSEE Complications the List only one case as a Due to be	cametan Fir	a death. Drilline. St Ba a death. Drilline. Sheduence Cychence One resultin	or other place ptist 22 22 22 22 22 22 22 22 22 22 22 22 22	26. PLER: Ursing Hon	neter ne	Ing, suc	Part i.	Home moke ardiec processes and areas	POCCC Cit reapira R As An Ai Ai Cres 2 j HOW INJ	DIMONOR INTERPRETATION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	Md. Treat, 241	218 Applinte On G S b. WERE AU AVAILABL COMPLET OF DEATH	proximate erval Between and D P Garage Grand D P Garage Grand D Grand To Topsy Finding To Topsy Finding To Topsy Finding Finding Topsy Finding	vee leat

DEATH (ITEM 27) (Type, Print)

0. 4421 BEECHWOOD

32 REGISTRAR'S SIGNATURE

1995



1 -	FOR STATE REGISTRAI
1. D	ECEDENT'S N

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIFIC	CATE	OF DEATH	REG. NO).		
		1. DECEDENT'S NAME (First, Middle, Last) WILLIAM	AUGUST	U.S	HNE	et Jr.	1.0	MY	YEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In		IF UNDER 1 YE	UI.	7. DATE OF BIRTH	4		ACE (State or Foreign
		215-10-4090			ONTHS DA		(Month, Day, Year) 4/13/191		Country)	land
3 should		9a. FACILITY NAME (If not institution, give st	reet and number)		b. CITY, TO	WN OR LOCATION OF D			TY OF OEAT	
2,	DIRECTOR	Carroll County	Gn. Hospit	tal	West	tminster		Ca	rrol	1
les 1,	<u>n</u>	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO	OCATION			10	od. INSIDE CITY
burial-transit permit. Pages 1,	1	Maryland Carr	oll	Wes	tmins	ster				LIMITS?
it per	FUNERAL	100. STREET AND NUMBER				101. ZIP COOE	-			T COUNTRY?
l-trans	NE I	1029 Hook Road	12. WAS DECEOENT EVER IN	U.S. ARMED	13 WAS	21157	NIC ORIGIN? (Specify Ye			States
the buria	BY FI	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	It yes	s, specify Cuban, Mexico YES 2 X NO Specifi	in, Puerto Rican, etc.)	a or No.	Black, W Specify:	American Indian, white, atc.
5 should be detached for use as the notified at once.	ED	15. DECEOENT'S EDUC		18e. DECEOENT'S U	BUAL OCCUP	PATION	16b. KIND OF BU	ISINESS/INDU	STRY	W111 CC
for us	ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo life. Do NOT use	rk done during retired.)	g most of working				
ched	COMPLET	7		superv	isor		Wester	n Ele	ectr	ic Co.
be detach at once.	_	17. FATHER'S NAME (First, Middle, Last)	Talanami G				ME (First, Middle, Maider	,		
led a	BE	William August 198. INFORMANT'S NAME (Type/Print)	Lennert Si		DDDEER (O.	Sadie	Route Number, City or Tox	ice		
e 5 should notified	2	Alice S. Lehne	rt				estminste			1157
director, page er must be		20a METHOD OF DISPOSITION 1 N Burtal 2 Cremation 3 Ramo	oval from State come			N(Neme of 4/26/		CATION — CI		
directic		4 Donation 8 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LIC	We	estmins	er (Cemeterv	We	stmin	nste:	r, MD
e funeral di I. examiner						tts Fund	eral Home	& C1	napei	1
	_	Kathereni PA	itto - Sweitzer		412	Washing	ton Rd	Moci	-min	ster. MD
in by rem		23. PART I. Enter the diseases, or c shock, or heart fellure. I	omplications that caused t	the deeth. Do no ch line.	enter the	mode of dying, aud	h aa cerdlec or reep	retory erre	et,	Approximate interval Between
₩ P P		IMMEDIATE CAUSE (Finel disease or condition	MADRAMA	A A.C. C	· nah					Onset and Death
completely fille ial, cremation, cevent, the	H	resulting in death)	MACRONO	CONSEQUENCE OF:	AKKI	OSIS OF	LIVEK			1 YEAR
	2		HEPATITIS							20 YEARS
OF	CATION	Sequentially list conditions, if any, leading to immediate	de	CONSEQUENCE OF):						
physician e prior t		CAUSE (Disease or Injury	BL000 7		sion					84 84
ding phy tygiene p	ERTIFI	that initiated events resulting in deeth) LAST	OUE TO (OR AS A C	CONSEQUENCE OF):						
the attending Mental Hygien ijury, or oth	CE		l							
- D	CAL	PART II. Other algnificent conditions	contributing to death but				Part I. 24s. WAS AN			RE AUTOPSY FINDINGS
signed by Health an	EDIC	1) IQOXW IE	exicity, As	TRIAL P	Daille	4 tion	1 YES :	XNO	CO	MPLETION OF CAUSE DEATH?
been s . of H show	Σ	DID TOPACCO LICE CONTR	MOUTE TO CALICE OF	DEATH VEC					10	TES 2 NO
has b Dept.	SICIAN:	DID TOBACCO USE CONTR		DEATH YES			4 🗆 📗			
certificate has been the State Dept. of , or item 23 sho	SIC	EXAMINER?	HOSPITAL:		THER:	Home 5 - Rasidence	0 T Other (On 1914)			
	PHY	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c.	INJURY AT	28d. DESCRIBE HOW	NJURY OCCU	REO	
fter this cath with marked	ВУ	Netural 5 Pending 2 Accident Investigation	NA	JULMI		WORK?				
R: After de	ED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, etc. (Specify	At home, term, etro	et, factory, c	office	28t. LOCATION (Street City or Town, State)		Rural Route	Number,
OIRECTOR: After this hours after death with item 28 is marker		An OFFICIEN								
국 인 노	OMPL		CIAN: To the best of my knowled R: On the besis of examination a							d manner ea stated.
FUN With	Ü U	296. SIONATIONE AND TITLE OF CERTIFIER				29c. LICENSE NUI				onth, Day, Year)
TO THE FUNERA De filed within 7 IMPORTANT: 1	0	Thomas K. (Salvia In r	-		D316				5
	2	30. NAME AND ADDRESS OF PERSON WHO								
		31. DATE FILED (Month, Day, Year)	ALVIN MO		NASI	HINGTON	RA WE	STMIN	ISTER	mo 21157
		APR 26 1995 July	02. REGISTRARY SIGNAT	, one						

MACRONCOULAR CIRRHOSIS OF LIVER

HEPATINI B

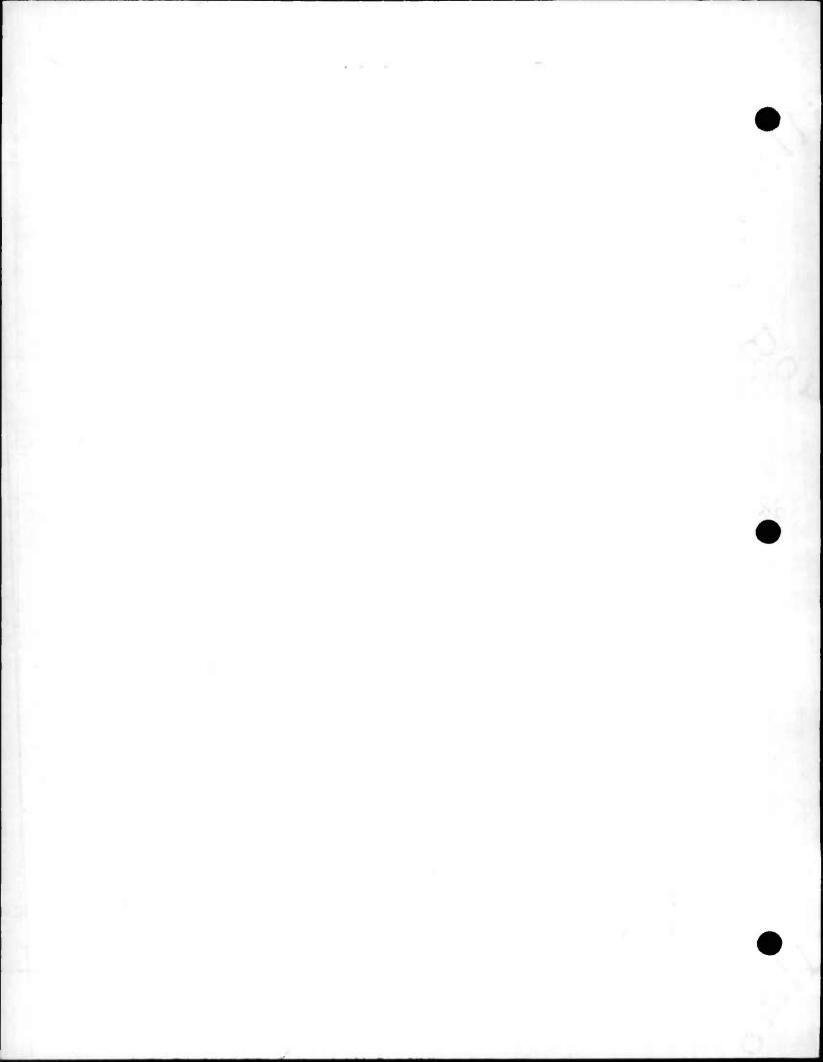
BLOCD TRANSFOSION

SONOFOC

SIABY 1

Item, 27 per MEO - Local Health Dept. P.G., GC, 4/10/95
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	FICATE OF	DEATH		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last CATHERINE			LIV	ERETTE	2. DATE OF MONTH	DEATH DAY	YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)			MAR			6:00P •
	233-36-9336	1 🗆 M 2 🗓 F 6	8 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF (Month, L	by 19,1927	West	ACE (Steep or Foreign harleston Virginia
OR	99. FACILITY NAME (If not institution, give WASHINGTON AI		SPITAL		MA PARI		9c. COUNT	Y OF DEAT	
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	TY	100 01	TY, TOWN OR LOCA	TION				
. DIRECTOR	Maryland Princ	e George's		attsvill				1	LIMITS?
FUNERAL	100. STREET AND NUMBER 5616 30th Avenue			10	20782		Unite	ed St Meric	ates
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, OIYE WAR OR (2XXNO	If yes, sp	ENDENT OF HISP/ ecity Cuben, Mexic 2 NO Spec	an, Puerto Rici	Specify Yes or No- 1	4. RACE -	American Indian, White, etc.
TED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	(Give kind of	S USUAL OCCUPATE	ON ost of working	16b. Ki	NO OF BUSINESS/INOU		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Switchb	oard Ope	rator	Gi	ant Food (Corpo	ration
	17. FATHER'S NAME (First, Middle, Last) John Howard Cummu	ngs			1	AME (First, Mide V. Kes	dle, Maiden Surname)		
BE	19e. INFORMANT'S NAME (Type/Print)	-0-	19h MAILIN	O ADDRESS (Street			City or Town, State, Zip C	a de l	
2	Timothy A. Corley						t, Marylar		770
	20a, METHOD OF DISPOSITION 1 \(\text{M} \) Burlel 2 \(\text{Cremation} \) 3 \(\text{Ret} \) 4 \(\text{Donation} \) 0 ther (Specify)	noval from Stata CO	b.PLACE AND DATE metery, cremetory or igh Lawn	other plecel		475	Oak Hill		State t Virginia
	21. SIGNATURA OF FUNERAL SERVICE L			22. NAME A	ND ADDRESS OF F	ACILITY	Joak HIII	, wes	c virgini.
	Khumid	Alcour-	- W	1 Tyree	Funeral	Home	ak Hill, V	m 25	901
11.00	23. PART I. Enter the diseases, or	complications that cause	d the deeth. Do	not enter the mo	de of dying, su	ch es cerdied	or respiratory arres	it,	Approximete
	IMMEDIATE CAUSE (Fine)	Arterios	each iine.						Interval Between Onset and Death
ı	resulting in death)	8	A CONSEQUENCE O		abcular	orseas	-		!
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR AS	A CONSEQUENCE O	PF):					ļ
TIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	PF):					
CER		d							
EDICAL	PART II. Other significent condition	ns contributing to deeth t	but not resulting	in the Underlyin	g ceuse given in	Part I. 24	PERFORMED?	CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	DE DEATH Y	ES I NO I	UNCERTAI	/	,	1[YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only one)	ONCERIA	14 0 1			
Š	MXYES 2 □ NO	HOSPITAL: 1 ☐ Inpatient 2√27/P/Out	patient 3 🗆 DOA	OTHER: 4 - Nursing Hom	e 5 🗆 Reeldence	6 Other (S	pec/fy)		
PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN		URY AT RK?	28d. DESCRI	BE HOW INJURY OCCU	RED	
B	2 Accident Investigation	26e, PLACE OF INJURY	/ — At home form		ES 2 NO				
TED	4 Homicide 8 Could not be determined	building, etc. (Spe	cify)	street, factory, ome		City or T	ON (Street end Number or bwn, State)	Rural Route	Number,
COMPLET	29a. CERTIFIER (Check calv one) 2 X Needical Examin	ICIAN: To the best of my know ER: On the basis of examination	riedge, death occurr on and/or investigation	ed at the Ilme, date on, in my opinion, d	end place, end du	to the cause(e) and manner ae atated. I place, and dua to the o	couse(s) an	d menner es atated.
H	256. SIGNATURE AND TITLE OF CERTIFIE		M		O . C . N	MBER			onth, Day, Year) H 30/95
2	30. NAME AND ADDRESS ON PERSON WI	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type 111 PEN	NN STRE	ET, BAI	TIMOR	RE, MARYI	AND	21201
	31. DATE FILED (Month, Day, Year) APR 1 U 1995	32. REGISTRAR'S SIGN							
- 11	LILITA IOOO 1								



ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-723 5/19/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH WILLIAM LASTER APRIL OF 1955 0930 Aw 4. BOCIAL SECURITY NUMBER 5 SEY B. BIRTNPLACE (State or Foreign 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 XXM 2 | F 220-62-6561 August 31. North Carolina Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH DEATON MEDICAL CENTER DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 16b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary land Prince George's Brandwine permit. 1 1 VES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 6804 Burchhill Road 20613 BALTIMORE, MARTLAND.

Nours after death. Page 6 may be retained by the hospital or attending physician.

Frame, name 5 should be detached for use as the burial-tran ILS.A 11. MARITAL STATUS 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yea, specify Cuben, Mexican, Puerio Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 XX Merried Specify: Black B 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Truck Driver 17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Meidle at Willie J. McNeill BE (William Laster notified 19e. INFORMANT'S NAME (Type/Pr 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Karen Laster (Wife) 2437 Kent Village Place Landover, Maryland 20785 pe 20e METHOD OF DISPOSITION
1 Disposition 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must of Torto Lincoln Cemetery 4/13/9\$ Brentwood, Maryland 21. SIGNATURE OF PUNERAL SERVICE LA examiner 22 ROTTINS Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 medical 23. PART i. Enter the disesses, or comfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by Approximate shock, or heart fellure. List only one cause on each line intervsi Between **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition resulting in death) STABWOUNDS WITH COMPLICATIONS executed within event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician and con Health and Mental Hygiene prior to burial, other traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 | YES 2 | NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has b. Dept. PHYSICIAN: DR ATTENDING PHYSICIAN; The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate that the State HOSPITAL:
1 A inpetient 2 ER/Outpetient 3 DOA OTHER: 1 XYES 2 NO 4 Nursing Name 5 Residence 6 Other (Specify) 27. MANNER OF GEATN this c 28e. DATE OF INJURY (Month, Day, Year) marked. 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 3/11/95 9:55 PM BY 1 YES 2 1 NO SUBJECT WAS STABBED After 1 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 3143 75TH AVE. 28 is DIRECTOR: / COMPLETED HOUSE LOCATED AT ANDOVER 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se atated HOSPITAL FUNERAL (2/__MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the ilms, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29A SIGNATURE AND TITLE OF 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) LOUR O.C.M.E APRIL 7,1995 2 PLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Alypaus KOLEUMM 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. OATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE APR 13 1995

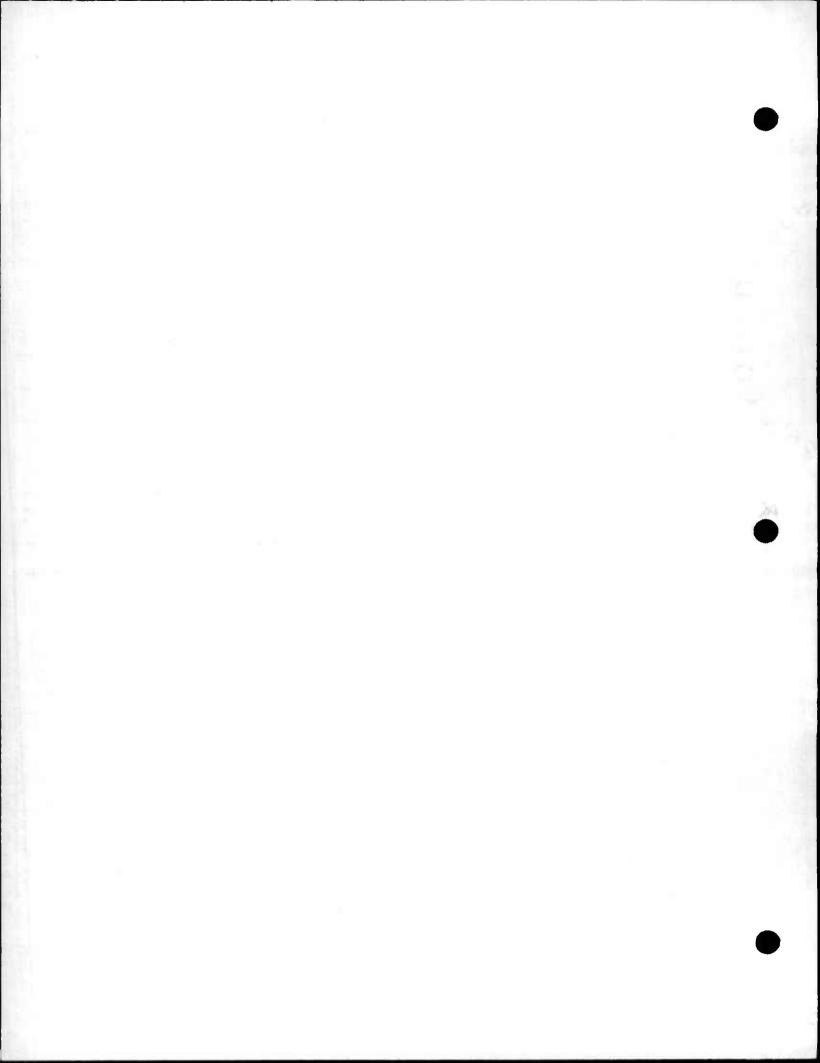
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permit. Pages 1, 2, 3 should

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

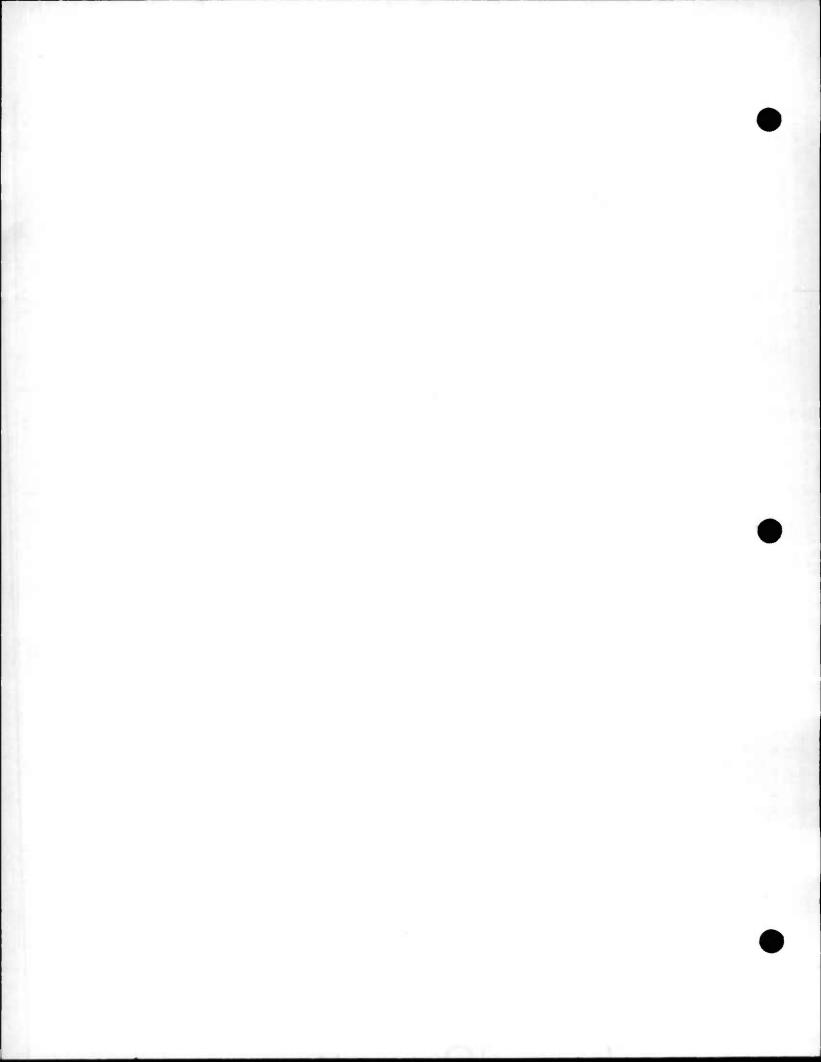
	1. DECEDENT'S NAME (First	Middle, Last)								2 DATE	OF DEATH			3. TIME OF DEATH
	DONALD	,	LEO				TE	WTS		MONTH	L 11,		YEAR	Control of the Contro
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDE		IF UNDER	24 HRS	7 DATE C	E BIOTH			02:05 A M
	232-48-20	65	1 🔀 M 2 🗌 F		YRS.	MONTHS	DAYS	HOURS	MIN.	Nov.	Day, Your) 1	930	WV	y)
	9a. FACILITY HAME (If not in	stitution, give s	treet and number)			9b. CIT	, TOWN	OR LOCATI	OH OF DE				NTY OF D	EATH
DIRECTOR	Sacred H		Hospita	11		Cu	ımbe	rla	nd			A.	11eg	gany
[[RESIDENCE OF DEC	10b. COUNTY	,		I too CIT	Y, TOWN	20 1 0047	1011						
Ĕ	WV		pshire		1000			hur	ches	3				10d. IHSIDE CITY LIMITS?
	10e. STREET AND NUMBER							ZIP COD				10a CIT	IZEN OF V	1 YES 2 XHO
BY FUNERAL	нс 74 во	x 189	D					267	65				USA	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDEHT C	OF HISPAN	IIC ORIGIH?	(Specify Yea	or No—		E — American Indian, k, White, etc.
7	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y		10			ecify Cube 2 X NO		n, Puerto Ri	ican, atc.)			
			WW 1											nite
H	(Specify on)	EDENT'S EDU	completed)	(G/	CEDEHT'S ve kind of Do NOT u	Work done	during mo	OH st of workin	ng	18b.	KIND OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0)-12)	College (1-4 or 5	1)		todi	an			W	V Sch	001	Dea	af & Blind
8	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTI	HER'S HA	ME (First, M	iddie, Malden	Surname)		
96	Laweren		wis							Lor				
6	19a. INFORMANT'S NAME (1	,,,	1								or, City or Town			
	Christin								D Th	ree				26765
	20a. METHOD OF DISPOSIT 1.X Burlal 2 Crematio 4 Donation 5 Other	n 3 🗆 Rem	oval from State	20b. PLACE A cemetery, crei	matory or o	ther place)				4/	100	CATION —		ches, WV
	21. SIGNATURE OF FUHERA		Thefit	Bran	CII			D ADDRE		CILITY	1 1111	ee v	CIIUI	.ches, wv
	1	. \ (\mathcal{X}	0		N	icKe	e F	uner	cal E	Home			
	23. PART I. Enter the di		Samuel and the	-Keal	-Al- Da	F	0.	Bo	x 27	70 Aı	igust	a, I	WV 2	6704
	anock, or h	eart failure.	List only one cau	ise on each line.	ath. Do I	iot enter	tna mo	ae or ayı	ing, suci	n as cardi	ac or respi	ratory en	reat,	Approximate Interval Between
	IMMEDIATE CAUSE (Fir disease or condition		(0.	77.0	h o		Course			E.				Onset and Death
	resulting in death)	→	DUE TO	(OR AS A CONSEC	UEHCE O	re	Le	u	7	1 4	elle	~		Lacy
z				COP	10				3					10 mg.
CERTIFICATION	Sequentially list conditi if any, leading to imme-			(OR AS A CONSEC		F):	-							23.
S	cause. Enter UNDERLYI CAUSE (Disease or Inju		c											
	that initiated events resulting in death) LAS	T	DUE TO	(OR AS A CONSEC	UEHCE O	F):								
E I			d				-							-
	PART II. Other aignifica	nt condition	s contributing to	death but not re	sulting	in the ur	nderiying	ceuse ç	given in i	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL	Dep.	se 2								_	1 YES 2	1.5		AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Ä												~		1 TYES 2 HO
ä	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF DEAT	TH YE	S 🔲 I	NO [UNC	ERTAIN	1 12				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF DEA	OTHEI								
ΥS	1 YES 2 TO HO			ER/Outpatient 3		4 🗆 Nur	sing Hom		sidence	8 🗌 Other				
	1.	Pending	28a. DATE OF (Month, D		28b. TIM INJ	URY		RK?	7.00	28d. DE\$C	RIBE HOW IN	IJURY OCC	CURED	
B	3 Sulate	Investigation	28a, PLACE O	F IHJURY — At hor	ne. ferm.	street fact		ES 2] HO	281 1.004	FIOH (Street a	nd Mumbas	or Primi 5	Austra Museubara
TED	= "	Could not be determined	building,	etc. (Specify)						City or	Town, State)	no reomos	or norar r	oute Number,
<u> </u>	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my knowledge, das	th occurr	ed at the t	lme, data	and place,	and dua	to the caus	e(a) and man	ner as stat	ed.	
COMPLET) end manner ee stated.
BEC	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c, LICE	NSE HUM	BER		29d. DAT	E SIGHED	(Month, Day, Year)
TO B	ward	Ire	200	y ans				0	54	846	,	► A	PRIL	12,1955
	30. NAME AHD ADDRESS OF	PERSON WHO	O COMPLETED CAUS			- (10,	ROB	ert	H.D.		-	7
2	31. DATE FILED (Month, Day,	Year)	32 DECISTRA	Z. U	en	he	le	wo	4,	uno	21) V	2	
	APR 2	0 199	SZ. NEUISTIA	R'S SIGNATURS	tall									
		- 1001												



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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH SOUTH SEARCH STATE OF DEATH SOUTH SEARCH			
	ALEX ROBERT LEE, Jr.			Jr.		March 27,		6:02 A M	
	4. SOCIAL SECURITY NUMBER 703-07-9371	1 X M 2 □ F 69	yrs. leet birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 19,		BIRTHPLACE (State or Foreign Country)	
OR	9a. FACILITY NAME (If not institution, give st Memorial Hospita				or Location of Darkerland		9c. COUNTY	y of DEATH	
ן בַּן	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY						71220		
DIRECTOR	WV Ham	pshire		v, rown on Locat pringfie				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 🌠 NO	
FUNERAL	P.O. BOX 2			101	26763		10g. CITIZE	N OF WHAT COUNTRY? US	
À	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y:	or No- 14	I. RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION	18a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATION Work done during mose retired.)	ON sst of working	16b. KIND OF BU	SINESS/INDUS		
OMP	10th		Welder	/boiler		Railroa			
- 1	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Melden Surneme)				
8	Alex Robert Lee, 19a. INFORMANT'S NAME (Type/Print)	Sr.	19h MAH ING	ADDRESS /Street a		Susan Har Route Number, City or Tow			
2	Shirley Lee						n, siene, zip co 26763	ide)	
	20s. PLACE AND DATE OF DISPOSITION DATE DATE DATE Cremation 2 Removed from State Camelary, cramatory or other place) March 29.								
	PL SIGNATURE OF FUNERAL MAYOR LICENSEE 22. NAME AND ADDRESS OF FACILITY Shaffer Funeral HOme, Inc., 230 E. Main Stromney, WV 26757								
	IMMEDIATE CAUSE (Fine)	List only one cause on ea	ch line.				iratory arres	t, Approximate intervel Between Onaet and Death 3 hours	
TIFICATION	resulting in death) e. Ruptured abdominal aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): 3 hours								
	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significent conditions	s contributing to death bu	t not resulting	In the underlying	Cause given in	Part I. 24s. WAS AN	AllToney	24b. WERE AUTOPSY FINDINGS	
MEDICAL	Severe arteriosclerotic cardiovascula				disease		ERFORMED? AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
AN: MED	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN								
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? Released 1 N YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)								
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCUR	IED	
à	1 Natural 5 Pending 2 Accident Investigation 2 Sublides 2 Sublides 2 See PLACE OF INJURY At hor			INJURY M 1 YES 2 NO ome, farm, atreet, factory, office		261. LOCATION (Street and Number or Rural Route Number,			
ETED	4 Homicide detarmined building, sic. (Specify)					City or Town, State)			
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.								
O BE COM	296. SIGNATURE AND TITLE OF CERTIFIER							9d. DATE SIGNED (Month, Day, Year)	
19 P	30. NAME AND ADDRESS OF PERIODS VILL	COMPLETED CAUSE OF DATA	Orint)	D 17456		DAPRIL 10, 1995			
	Dr. P. Schröeder, Memorial Hospital, Cumberland, MD 21502								
	31. DATE FILED (Month Day, Year) APR 1 3 1995 STREGIST PAR'S, SIGNATURE								

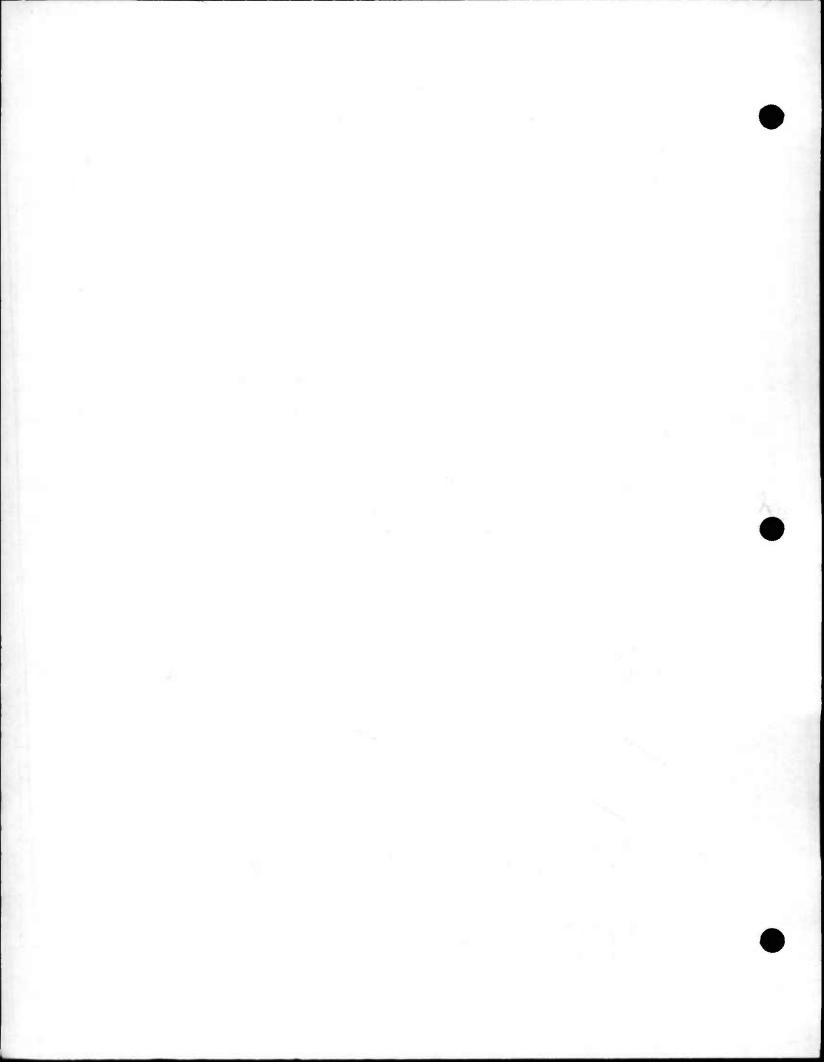


		REGISTRAR				CERTIF	ICATE	OF	DEATH		RE	EG. NO.				
	1	1. DECEDENT'S NAME (First,	Middle, Last)								DATE OF D	EATH DAY	,	YEAR	3. TIME OF DEATH	
		1		E MITCH	ELL					4 7	April			95	9:50 A	
	ÿ	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	. last birthday)	IF UNDER 1	-	IF UNDER 24 HR	S 7. I	DATE OF BI	RTH		8. BIRTH Countr	IPLACE (State or Foreign	
P		_215-12-61	.52	1 🗌 M 2 🔀 F	90	YRS.	MONTHS	DAYS	HOURS MIN	. '	10-1	4-1	904			
pinous		9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN C	OR LOCATION OF	DEATH			9c. COUN	_		
2,	DIRECTOR	SALISBURY NU	JRSING	& REHAB	CENTER	₹	SAL	ISB	URY, MI).			WICO	MIC)	
- -	ַוַ	RESIDENCE OF DEC	10b. COUNT													
Pages	E .	MD.		ICOMICO			Y, TOWN OF								10d. INSIDE CITY LIMITS?	
permit		10e. STREET AND NUMBER		ICOMICO			SALI	_							1 XYES 2 NO	
	FUNERAL							101	. ZIP CODE				10g. CITIZ	ZEN OF V	WHAT COUNTRY?	
020 physician. burial-transit	N N	11. MARITAL STATUS	. DI	VISION 12. WAS DECEDEN		101-50			218						S.A.	
020 physician burial-tra		1 Never Married 2	Married	FORCES? 1	YES 2	NO	31	yea, spe	ENDENT OF HIS solfy Cuban, Mar	dcan, Pu	RIGIN? (Sp larto Rican,	ecify Yaa o	or No—	o— 14. RACE — American India Black, Whita, alc.		
o pui	BY	3 Widowed 4 Divo	rced	IF YES, GIVE V	MAR OR DATES		1	YES	2X NO Sp	ecity:	y: Sp			Speci	WHITE	
21215-0020 al or attending physic for use as the burial-	8		EDENT'S EDU		16a,	DECEDENT'S	USUAL OC	CUPATIO	ON .		16b, KIND OF BUSINESS/INDUSTRY					
212	ETED	(Specify only Elementary/Secondary (0	highest grade	College (1-4 or 5	4)	(Give kind of life. Do NOT u	work done di se retired.)	iring mo	st of working							
	COMPL	, , , , , ,		6		EACHE	R& L	IBE	RARIAN		PUBLIC SCHOOL			OT.		
AND the hospit detached	0	17. FATHER'S NAME (First, Mi	iddle, Lest)							NAME (JCIIC	ЛОП	
at be to be		WILLIA	M WES	SLEY MI	TCHEL	18. MOTHER'S NAME (First, Middle, Maiden S LL LILLY PHIPPS						,				
MARYLAND retained by the hospit should be detached notified at once.	BE (19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRESS	(Street a	nd Number or Ru				State, Zip	Code)		
	유	LETITIA	BATI	ES											4D.21853	
RE, may be or, page	. 1	20a. METHOD OF DISPOSITI		MARKE VICES	20b. PLA	CE AND DATE		-		1	DATE		_	ION — City or Town, Stata		
ALTIMOR eath. Page 6 mar funeral director, p		1 Donellon 5 Other		oval from Stata	cemetery,	ARSON	s CE	MET	ERY	4	-19	SA	LISE	RIIRY	MD.	
Pag al dir		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE,	1.	71			D ADDRESS OF			011	DIOI	3()1()	. Trib.	
	ш	16.	4/-	10	+	/		ВО	UNDS	FUN	ERAT	HO	ME.S	T.TAS	SBURY, MD	
after of the moval.	Н	22 DADEL Enter the di	"X	1	nus	7/									. BECKT / HE	
d in b or ren		23. PAPT I. Enter the di shock, pr he	eart feilure	List Dniy one ceu	ise Dn sech i	ine.	not enter t	ne mo	da of dying, s	uch ss	csrdisc o	or respire	atory arre	est,	Approximate intervel Between	
filled on, or	19	IMMEDIATE CAUSE (Fin	ei			1	. /			٦	0				Onsat and Deat	
d within 24 completely fille event, the		disease or condition resulting in deeth) a. Consessive plans Parline years														
			DUE TO (Off-AS A CONSEQUENCE OF):													
OX 687 or be executed sician and control burial, traumatic er	8	Sequentielly list conditi	one,	b	(OR AS A CON	SECUENCE O				-						
be e iclan ior to	F	If any, leeding to immed cause. Enter UNDERLYI		A	-6P2	Os.	5		Hen	25	-0	200	200			
O. B. ertificate ing physical progression of their t	윤	CAUSE (Disesse or Inju		c. DUE TO	(OR AS A CON	SEQUENCE O	FI.		100/11		1	2	0-332	_		
. 0 0 -	Ē	thet initiated evants resulting in death) LAS	т 📗		(,.								j	
- C C -	CERTIFICATION			d												
i g a a a	¥	PART II. Other significs	nt condition	s contributing to	desth but no	ot resulting	in the und	eriying	ceuse given	in Part	i. 24a.	WAS AN A		24b.	WERE AUTOPSY FINDINGS	
that the by the any	DICAL	Deman	io								1 -	PERFORM			AWAILABLE PRIOR TO COMPLETION OF CAUSE	
quires thin signed f Health and	MEC	Row	se	RAI	line						1	1	2)		OF DEATH?	
S - 8 - 2	ÿ	DID TOBACCO U	SE CONT			EATH YE	S \square N	0 🗆	UNCERTA	AIN [٦				10.10	
VITAL AN: The lav ifficate has state Dep	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?				LACE OF DEA		_			=					
F VITA SICIAN: The certificate h the State C	SIC	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outpetlant	3 DOA	OTHER:		s 5 Realden	e 6 🗆	Other (Soe	cifv)				
T 55 55 5	PHY	27. MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIM	/	8c. INJ	URY AT		I. DESCRIB		JURY OCC	URED	· ·	
NG PHYS fler this eath with	ВУ		Pending nvestigation	(Month), D	ay, rour/		М	1 Y	ES 2 NO							
J D A D M		2 - Sutates	Could not be	28a. PLACE D	F INJURY — At atc. (Specify)	home, farm,	street, factor	y, office	1	281	LOCATION	(Street an	d Number o	or Rumal F	Route Number,	
- 55 6 6 1	ETE	4 Homicida	determined		atal (opcony)						City or Tow	m, State)				
- K K D 5	凒	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my knowledge.	death occurr	ed at the tin	o deta	and place, and o	tue to th	o couse/s)	and mann	ar an eleta	d		
PITAL ERAL 72 n	COMPL) and manner as stated.	
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If its	_	29b. SIGNATURE AND TITLE			14-24-5-4											
로 를 되는 B	BE	7	1 -		10-				29c. LICENSE I				29d. DATE	SIGNED	(Month, Day, Year)	
2 6 5 ₹	2	30. NAME AND ADDRESS OF	PERSON WH	D COMPLETED CAUS	SE OF DEATH	TEM 97) /5/0-	Print)		D-290	113			7	10	1170	
		MICHAEL ATK						TTC	א עמוזמ	(ID						
		31. DATE FILED (Month, Day,	Year)	32. REGISTRA	B'S SIGNATUR	EV D	IX. / SP	m TO	DOI(I)	т.						
	12		L 9 199	5 Jahrio	B'S SIGNATUR	Kardalk										
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

a. 5. J. F. K., 15 + 16 4;

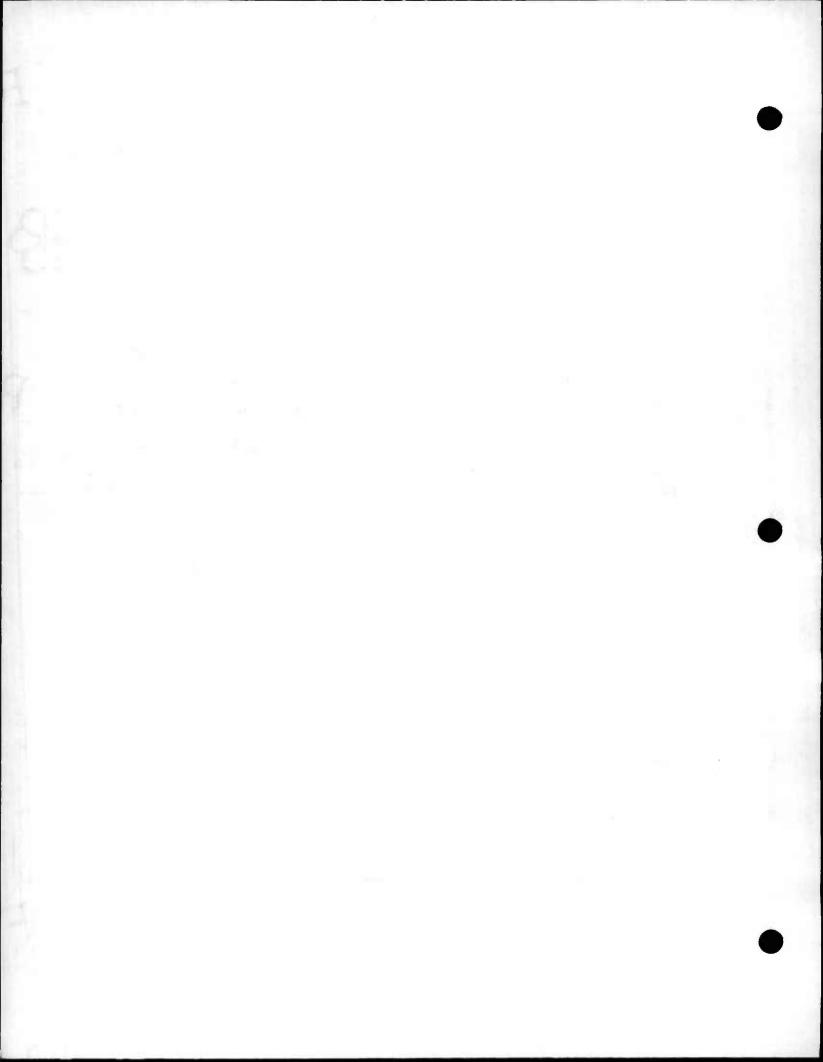
			1 - STATE STATE CERTIFICATE OF DEATH REG. NO.	
•			1. DECEDENT'S NAME (First, Middle, List) Lucy B. MacDonnell 2. Date of Death Month, April 20, 1995 Year 8:20 P.	м
	pi		4. SOCIAL SECURITY NUMBER 214-05-0707 S. SEX 1 M 2 X F 8. AGE (In yrs. lest birthday) 1 WRS. 8. AGE (In yrs. lest birthday) 1 WONTHS DAYS HOURS MIN. 9. BIRTHPLACE (State or Foreign Months) 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 2 X F 1 M 3 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	
	, 2, 3 shou	стов	9e. FACILITY NAME (If not institution, give street and number) Fairfield Nursing Home RESIDENCE OF DECEDENT 9b. CITY, TOWN OR LOCATION OF DEATH Crownsville 9c. COUNTY OF DEATH Anne Arundel	
	physician. burial-transit permit. Pages 1, 2, 3 should	DIREC	10e. STATE Maryland 10b. COUNTY Anne Arundel 10c. CITY, TOWN OR LOCATION X 10d. INSIDE CITY LIMITS? X Crownsville 1 □ YES 2 ☑ NO	
	ansit perm	FUNERAL	10a. STREET AND NUMBER 107. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1454 Fairfield Loop Road 21032 United States	
5-0020	ling physicia the burial-tr	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 2 Merried 3 Merried 4 Divorced 1 Never Merried 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, White, etc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, White, etc.)	
D 21215	spital or attend	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 12 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16c. Clerk Banking	
MARYLAND	led by the hospit nuid be detached ed at once.	BE	17. FATHER'S NAME (First, Middle, Last) Lemon Beall Jr. Lucy Collinson 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number of Burel Route Number City or Tourn State, Tip Code)	
BALTIMORE, MARYLAND 21215-0020	ay be retained page 5 should t be notified	5	Ninian Beall (brother) 205 Coulbourne Lane Snow Hill, Maryland 21863	
	director, p		20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of A Donation 5 Other (Specify Hallows Chapel Cemetery 4-24-95 Davidsonville, Md.	
BALTI	ter deam. Page 6 m the funeral director, wal.		22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md.2140	01
14	d in or re		23. PART I. Enter the diseases, or complications that caused the dasth. Do not anter tha mode of dying, such as cardiac or respiretory srrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	
	nat the deam certheate be executed within 24 to by the attending physician and completely filler and Mental Hygiene prior to burial, cremation, by Injury, or other traumatic event, the	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST	_
O :	w requires that the death is been signed by the atten pt. of Health and Mental is shows any injury, o	MEDICAL CEI	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
Ī.	S p p	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only of b) EXAMINER?	
OF	this certification with the riked, or	BY PHYSI	MOSPITAL: 1 YES 2 NO	+
	A after d	TED	3 Suicide 6 Could not be distermined 28e. PLACE OF INJURY — At home, farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
۵		COMPLI	29e. CERTIFIER (Check only one) ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.	
ļ	TO THE HUSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	TO BE	29c. LICENSE NUMBER D-19528 29d. DATE SIGNED (Month, Day, Year) 4-21-95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Rose Police)	
			Elmo M. Gayoso, M.D. 5411 Old Frederick Rd. Baltimore, Md. (Ph.#410-744-3950)	
			31. OATE FILED MONTH OF 1995 32. REGISTRAR'S SIGNATURE	



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				ICALE	OI.			F				
	1. DECEDENT'S NAME (First, Middle,	/							2. DATE OF	DEATH	,	YEAR	3. TIME OF DEATH
		sie McGuc	kian						April			TEAR	3:15A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1		IF UNDER		7. DATE OF I	HTRI		8. BIRTH	IPLACE (State or Foreign
	220-44-3199	1 🗆 M 2 🕽 🗲		YRS.	MONTHS	DAYS	HOURS	MIN.	Nov		902	Ma	ryland
	9a. FACILITY NAME (# not institution,	give street and number)			9b. CITY, T	O MWO	R LOCATIO	ON OF DEA	NTH		9c. COU	NTY OF D	
9	Annapolis Nursi	ng & Rehab	Center		Α	nna	apolis	;			Anr	ne A	rundel
ᇈ	RESIDENCE OF DECEDEN			7 -							7 (111	10 /	Tarioci
<u>E</u>	100.0	nne Arunde	1	10c. CIT	Y, TOWN OR								10d, INSIDE CITY
	10e, STREET AND NUMBER	Title Alunde			AI		polis						1 1 YES 2 NO
FUNERAL DIRECTOR				10f. ZIP CODE						10g. CIT	IZEN OF V	VHAT COUNTRY?	
빌	602 Burnside S							1403				nite	d States
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDE FORCES?	NT EVER IN U.S. A	RMED	13. WA	S DECI	ENDENT O	F HISPANII	C ORIGIN? (S. Puerto Ricar	pecify Yee	or No-	14. RACI	— American Indian, c, White, atc.
à	3 X X/idowed 4 Divorced	IF YES, GIVE	MAR OR DATES				ES 2 XIOX Specify: Specify:						
	15. DECEDENT'S	EDUCATION	160.5	DECEDENT'S	I I COO	LIDATIO			401 1/10				AAIIICO
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEOMAC 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)							DUSTRY						
瞐	12 Homemake					akei	r		1		ы	ome	
No.	17. FATHER'S NAME (First, Middle, Las	0			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11101		ED'S NAM	E (First, Middl	Maldan f		Jille	
	Benjamin L	eitch				- 1	10, 10011		artha		,		
BE	19a. INFORMANT'S NAME (Type/Print)			95 MAILING	ADDRESS /	Street as	nd Number		oute Number, (Code	
임	Alfred B. McG	uckian							Annapo				2
	20a. METHOD OF DISPOSITION		20b. PLACI	EANDDATEC				,	DATE		ATION -		
	1 Surial 2 Cremation 3 C	Removal from State	Selery, c	Anne's	her place)	ete	erv.	4/26/	/95				Maryland
- 1	21. SIGNATURE OF FUNEBAL SHIVE	E LIPENSEE	17	, tillo t	22. NA	ME AN	D ADDRES	S OF FACE	UTY Joh	n M	Tay	dor l	uneral Home
- 1	Horizollall	1. 4.	Yu -		14	7 6	Duko	of C	Nouse	11 171	nay	101 1	uneral mome
\dashv	147 Duke of Gloucester St. Annapolis, MD 2. PART I. Enter the disesses, or complications that caused the desth. Do not enter the mode of dying, such ea cerdiec or respiratory strest, Approximate												
	ahock, or heart fall	ure. List only one ca	it ceused the d use on each lir	lesth. Don ne. (ot enter th	e mod	da of dyle	ng, auch	ea cerdiec	or respir	atory sr	est,	Approximata interval Between
	IMMEDIATE CAUSE (Finel disease or condition	(p											Onset and Death
	reaulting in death)	sC	acur	u co									
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CERTIFICATION	Sequentially list conditions,	b. DUE TO	your	1 C	120	w	N	>4	rdu	n			
Ę I	if any, lesding to immediate cause. Enter UNDERLYING		(Only a Cons	A A	- /			V					
윤	CAUSE (Disease or injury that initiated events	C. DUE TO	(OR AS A CONSI	EOUENCE OF									
듄	resulting in desth) LAST												i
	PART II. Other significant cond	itions contributing to	desth but not	reaulting i	n the unde	rlying	ceuse g	lven in P	art I. 24a	. WAS AN A		24b.	WERE AUTOPSY FINDINGS
	PART II. Other significant cond	itions contributing to	desth but not	reaulting i	n the unde	erlying	ceuse g	iven in P		WAS AN A PERFORM	AED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL CE								iven in P		PERFORM	AED?	24b.	AVAILABLE PRIOR TO
MEDICAL	PART II. Other significant cond							Iven in P	_ 10	PERFORM	AED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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SABALTIMORE, MARYLAND 21215-0020

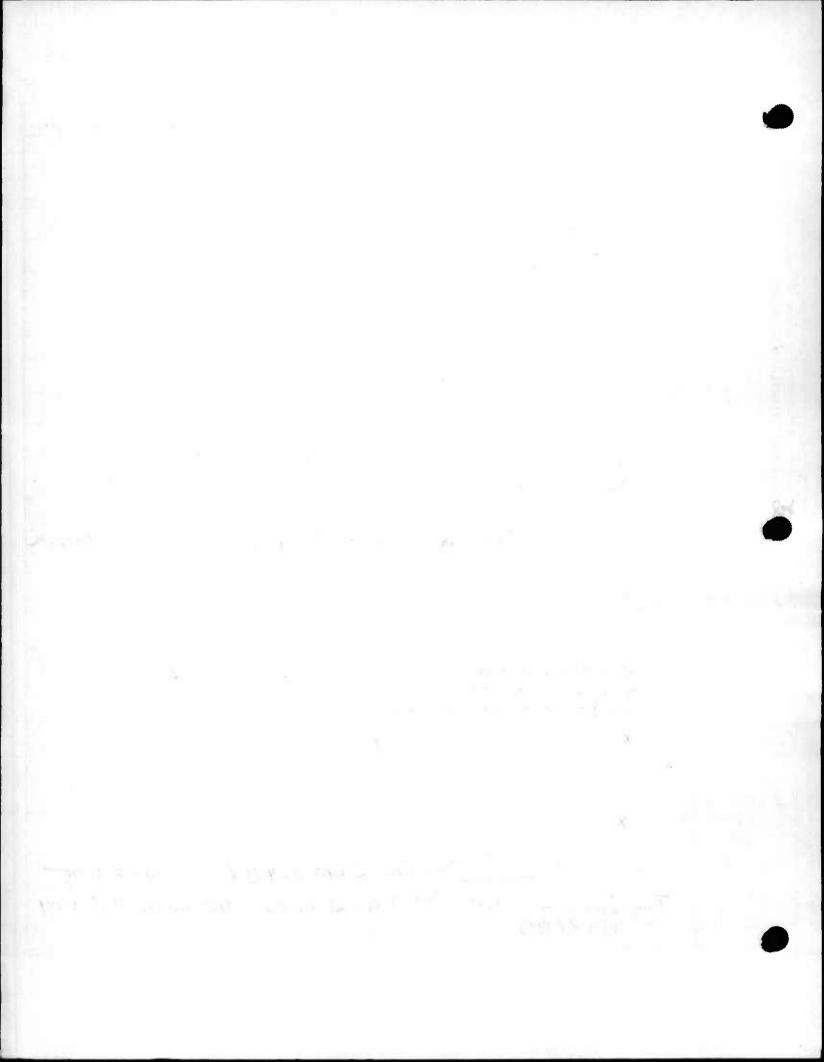
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within actious after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	#10abcdef.	FilmG724 6/13	3/95 kam						10070
	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT OF I	EALTH AND	MENTA	L HYGIEN		
	1. DECEDENT'S NAME (First, Middle, La	mc Cus ke				2. DATE	OF DEATH	W Y	YEAR 7:45 AM M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	. 7. DATE	OF BIRTH		. BIRTHPLACE (State or Foreign
	191-32-5146	1 🗆 M 2 💭 F	9 4 YRS.	MONTHS DAYS	HOURS MIN.		th, Day, Year)		Country)
	9a. FACILITY NAME (If not institution, gi	ve street and number)	94	9b. CITY, TOWN	OR LOCATION OF		9-190		Pennsylvania
œ									
18	Knollwood Mar	nor Nursing	Ctr.	Mil1	ersvil	lle		Anne	e Arundel
DIRECTOR	10a. STATE 10b. COU	Anne Arunde	10c, CIT	TY, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
		estmoreland	- T	rafford	Mille	rsvil	le		1 YES 2 NO
FUNERAL		ollwood Manor		Ctr. 10	f. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?
벌	403 Gilmore /	ve. 899 Ceci	1 Avenue		15085	2110	8	USA	A
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	R IN U.S. ARMED	13. WAS DEC	CENDENT OF HISP secify Cuban, Max	PANIC ORIGIN	N? (Specify Yea	or No — 14	I. RACE — American Indian, Black, White, atc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		2 NO Spe		ricali, etc.)		Specify:
	15. DECEDENT'S E	DUCATION		<u> </u>					White
	(Specify only highest gr	rade completed)	(Give kind of	S USUAL OCCUPATE work done during me use retired.)	ON ost of working	188	. KIND OF BUS	INESS/INDUS	STRY
=	Elementary/Secondary (0-12)	College (1-4 or 5+)					П.		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Teach	er	to MOTHER'S		Elem.		001
U U					100000000000000000000000000000000000000				7
100	John 19a. INFORMANT'S NAME (Type/Print)	Geary	195 MAII INC	ADDRESS (Street	Mary		ose		lughes
임	Rosemarie Del	7 2 1							x, MD 21146
	20a. METHOD OF DISPOSITION		0b. PLACE AND DATE			DAT			y or Town, State
	1 Donation 5 Other (Specify)	lamovat from Stata	emetery, crematory or c	other place)		1			
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	St. Jos		ND ADDRESS OF	FACILITY	E.	McKee	esport, Pa.
	1000	(<						495 F	Ritchie Hwy.
\vdash		auro	w	Barra	nco Fu	ınera	1 Hom	e Set	Ritchie Hwy. verna ParkMD
	23. PART Enter the diseases, shock, or heart failu	or complications that cause re. List only one cause on	ed the death, Do a each line.	not enter the mo	de of dying, a	uch as can	diac or respi	ratory srrea	Approximate interval Between
	iMMEDIATE CAUSE (Final disesse or condition	- 0		r	D /				Onset and Death
	resulting in desth)	a. Is ofu	muc H	lart	V15.00	50			month
_	_		A CONSEQUENCE O	r):					
CERTIFICATION	Sequentieily list conditions,	b. DUE TO (OR AS	A CONSEQUENCE O)F):					
¥	if any, leeding to immediate cause. Enter UNDERLYING	2		,					İ
핕	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):					
ᇤ	resulting in desth) LAST	d.							!
Ö	PART ii. Other significent condit	Name annialbudge as death							
Š	11 4		but not readiting	in the underlyin	g csuse given	in Part i.	24a. WAS AN	AUTOPSY MED?	24b. WERE AUTOPSY FINGINGS AMAILABLE PRIOR TO
EDICA	- Holan	soidism					1 TYES 2	KNO	OF DEATH?
Σ	Sprile	DEMENTIA							1 TYES 2 NO
N N	Liett	hip frac	tune						
D.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Check only or	ne)		
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou		4 Nursing Hon		_			
	1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year,	Y 28b. TIN	JURY WO	URY AT PRK?	28d. DES	SCRIBE HOW IF	JURY OCCUP	RED
B	2 Accident Investigation				YES 2 NO	-			
요	3 Suicide 8 Could not 4 Homicide detarmined	building, etc. (St	RY — At home, farm, pecify)	street, factory, offic	•	28f. LOC	ATION (Street a or Town, State)	nd Number or	Rural Route Number,
ш									
COMPLET	29a. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and dua to the cause(a) and manner as stated. MEDICAL EXAMINER: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner as stated.								
8	2 MEDICAL EXAM		on end/or investigation	on, in my opinion, c	eath occured at t	he time, date	end place, and	d dua to the c	cause(s) and manner as stated.
H	29b. SIGNATURE AND TITLE OF CERTIF	FIER	TELLI	1.1.	29c. LICENSE N	IUMBER	,	29d. DATE S	IGNED (Month, Day, Year)
0	20 NAME AND ADDRESS		17471	4MLING	272	1754	6	14	-25-95
	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type		·100 -	69	Con -	r 10	110 -1.00
	31. DATE FILED (Month, DO Pr)	7 10 ME REGISTRARIS SIG	SMATURE -	Famb	TIRLS R	d.	99m	brills	M.D. 21009
	APR' &	1985 Julia	Develor Res	ball					



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 hours after death with the State Dept, of Health and Mental Mygiene prior to burial, cremation, or removal.	
ALTI	death. F	funeral	
8 8	irs after	in by the	
44	TION	filled i	
, P.O. BOX 68760	eath certificate be executed witth	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
ITAL RECORDS	: The law requires that the de	cate has been signed by the attachment that and Men	
DIVISION OF VI	L OR ATTENDING PHYSICIAN	. DIRECTOR: After this certific hours after death with the S	

VA

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH 10300 Nathanael Morehead S. April 1995 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1921 8. BIRTHPLACE (State or Country) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 241-18-7411 1 XXM 2 - F 74 HOURS YRS. January 30 North Carolina 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bowie Medical Center Prince George's Rowie RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 1 YES 2 NO N. Carolina Guilford Greensboro FUNERAL 10e. STREET AND NUMBER 101, ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 4903 Tamaron Drive 27410 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XXES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married if yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAB OR OATES BY Specify: 3 Widowed 4 Divorced **Black** 16a. OECEDENT'S USUAL OCCUPATION

Third of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Personnel Executive Burlington Industries 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Wheeler S. Morehead Elizabeth Johnson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 16203 Aveston Place Bowie, MD 20716 Glendia R. Hatton å 20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE must 1 Buriet 2 Cremetion 3 S Removat from State
4 Donation 5 Other (Specify) Entombment Guilford Memorial Park 4/12 Greensboro, N. Carolina 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Robert Eyans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland 20715 Jans medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, shock, or heart fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition DUE TO (OR AS A CONSEQUENCE OF): rpeus resulting in death) event, traumatic CERTIFICATION Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 In arry, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? any 1 YES 2 AND OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PUNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? 26. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL: OTHER: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 - Mealdenca 8 - Other (Specify) 6 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO ВУ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 6 Could not be 4 Homicide 28 detarmined Tem 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL THE FUNERAL IT THE FUNERAL IT THE MITHIN 72 H 2 MEDICAL EXAMINER: On the besia of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 24c. LICENSE NUMBER B 2 (TEM 27) (Type, Print)

istrar's signature

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

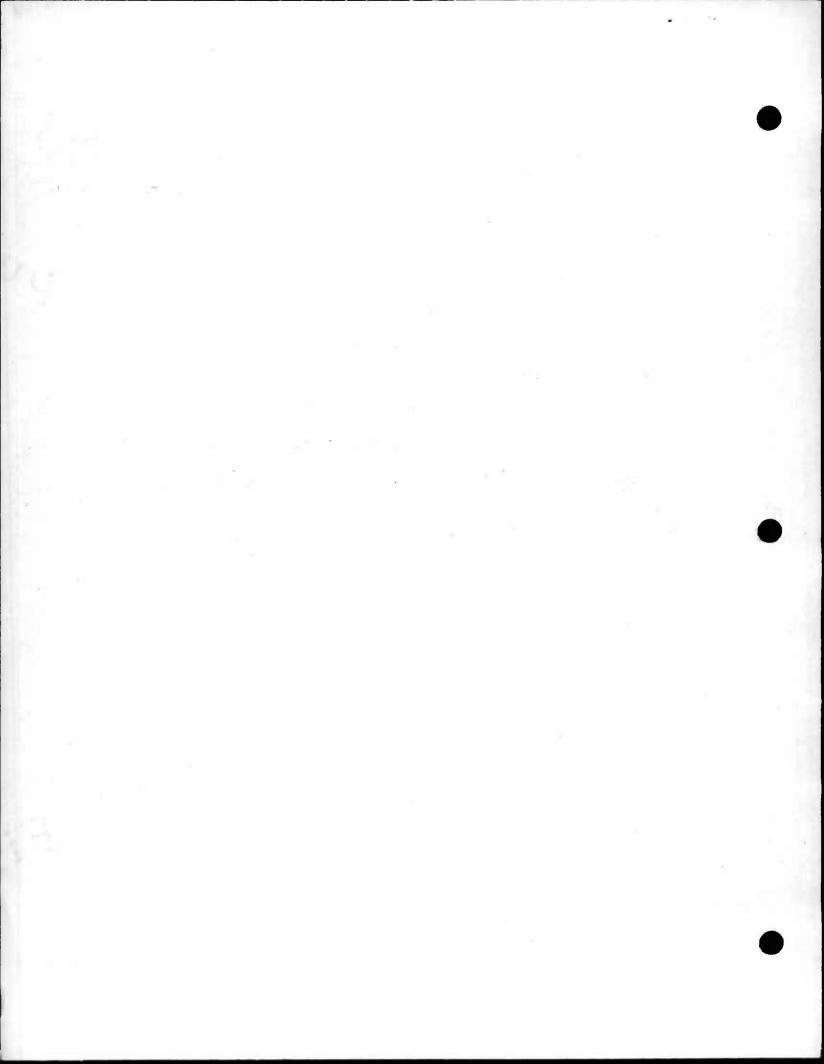
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netfiled at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF M		/ DEPAR					ENTA	L HYGIEN					
	1. OECEDENT'S NAME (First, Middle, Last)			<u> </u>	10		D 		2. DATE	OF DEATH	AY	YEAR	3. TIME OF	DEATH	
	ANDRE I	DESHAWN	15 1		MCK				APR	IL 06		95	3:28		M
	579-80-8622	6. SEX 1 ☑ M 2 ☐ F	6. AGE (In yrs.	. lest birthday) YRS.	MONTHS	DAYS	HOURS !	24 HRS. MIN.	(Monti	OF BIRTH		Countr	**		
	Se. FACILITY NAME (If not inelitation, give a	2.2	1/	1710.	Bb. CIT	Y. TOWN (OR LOCATIO	N OF DEA		-31-7		Was	h. D.	.C.	_
NO N	PRINCE GEORGES		AL			EVER		// UT UL.			Land of the same of		GEO	RES	-
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	ν		10c. CIT	TOWN	CR LOCAT	-				2.500	166	One of the		_
DIRECTOR	District of Co	•		10c. CITY, TOWN OR LOCATION Washington									10d. INSIDE LIMITS	7	
AL	10e. STREET AND NUMBER						ZIP COOE				10g. CITIZ	ZEN OF W	VHAT COUNT		_
FUNERAL	4213 Brooks St	reet N.I	E. #2	.03			200	19			Uni	ted	Stat	tes	
5	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT FORCES? 1	YES 2	ARMED	13.	WAS DEC	ENDENT OF	HISPANIC	C ORION	? (Specify Yes	or No-	14. FIACE	- American t, White, sto.	Indian,	
BY	3 Widowed 4 Olvorced	IF YES, OIVE WA	A OR DATES				2 💢 NO		1200			Speci			
E	15. DECEOENT'S EDU (Specify only highest grade	CATION	16a.	DECEDENT'S	USUAL O	CCUPATIC	ON		16b	KIND OF BU	BINESS/INDI		lack		
	Elementary/Secondary (0-12) College (1-4 or 5+) Ife. Do NOT use retired.)														
COMPLETED	12th Student N/A 17. FATHER'S NAME (First, Middle, Lest)														
8	17. FATHER'S NAME (First, Middle, Last) William T. Brooks, Jr. 18. MOTHER'S NAME (First, Middle, Melden Surname) Patricia McKoy							V							
) BE	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							203		_					
٩	Patricia A. McKoy 4213 Brooks Street N.E., Washington, D.O.).C.							
	20a METHOD OF DISPOSITION 1 Note: Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of complexy, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of complexy, crematory or other place)														
	4 Donation & Other (Specify) Harmony Mem. Park Ceme. 4/11/95 Landover, Md.														
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME														
	4001 Benning Rd. N.E., Wash. D.C.														
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								ximsta ai Batwe	en.						
	IMMEDIATE CAUSE (Final disease or condition	C	-1-04	L \1/	3 - 1		r (7)	1					and Dae	
	resulting in death)	a. Gur	OR AS A CON	SEQUENCE O	oun.	0	+ 0	ne	5+				-		_
z	Properties and appearance	h			,										
5	Sequentially list conditions, if any, leading to immediate	DUE TO (C	OR AS A CON	SEQUENCE OF	*):								1		
5	cause. Enter UNDERLYING CAUSE (Disease or injury	c	DR AS A CON	SOURNOE O	5.										
CERTIFICATION	that initiated events resulting in death) LAST		M AS A COM	BEOUGHUE OF	*) :										
	TART II ONLY I WILLIAM TO MAKE	d													
MEDICAL	PART II. Other eignificant condition	e contributing to d	eath but no	t resulting	In the ur	iderlying	causa gi	van in Pi	art i.	24a. WAS AN PERFOR		24b.	WERE AUTOPE	OT ROSE	
Ē									-	1 YES 2	□ NO		OF DEATH?		
Σ.	DID TOBACCO USE CONTI	DIRLITE TO CALL	ISE OF DI	IV LITA	S 🗆		LINCE	RTAIN	- 1				1 € YES 2	□ NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CIDOTE TO CAS		LACE OF DEAT			UNCE	KIAIN							\dashv
SIC	EXAMINER?	HOSPITAL:	ER/Outpetient	3 × DOA	OTHE		6 🗆 Resi	idence 6	☐ Other	(Specify)					
F	27. MANNER OF OEATH	28s. DATE OF IN (Month, Day,		28b. TIM INJ		28c. INJU	JRY AT	, 2	ed. DES	CRIBE HOW I	1 6	UREO			7
BY	1 Natural 5 Pending 2 Accident Investigation	4/6/9	5	24	7 M	1 🗆 Y	ES 2 🗹	NO	subj	093.	hot				
	3 Suicide 5 Could not be 4 Homicide determined	28e. PLACE OF building, at	tc. (Specify)	2 1 4		ory, office		12	City	TION (Street a	567 F	RITCH	houte Number,		
9	29e. CERTIFIER			build	-77	- 1/-			Cap	tol He	9kk	Hol			_
COMPLETED	290. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end memor es stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end memor es stated.														
8	29b. SIGNATURE AND TITLE OF CENTIFIAN (20 CENTIFIAN 29b. SIGNATURE AND TITLE OF CENTIFIAN 29b. SIGNATURE AND TITLE OF CENTIFIAN (20 CENTIFIAN 29b. SIGNATURE AND TITLE OF CENT														
BE	14 1	Chut	2 110			- 1							(Month, Day, Y		
요	30. NAME AND ADDRESS OF PERSON WHI	O COMPLETEO CAUSE	OF OEATH (I'					.M.I					06,1		
	Dennis J. Chu	te, M.D.		11	11 N	. P	ENN	STR	EET	. BAL	TIMO	RE,	MARYI	LAND	
	31. DATE FILEO (MONTH, Day, Year) 31. AFOISTRAN'S SIONATURE ADD 11 1995 Files Davidson Randall														



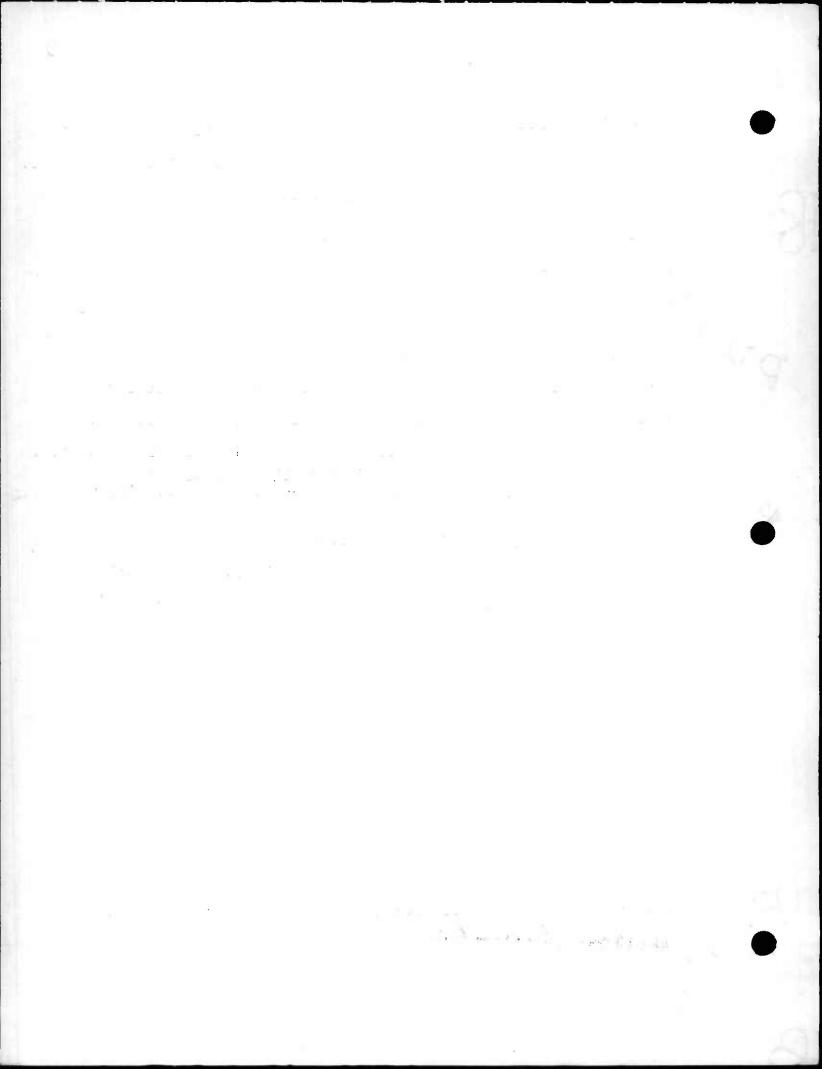
DIVISION OF VITAL RECORDS, P.O. BOX 68760, September 1215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four's after death. Page 6 may be retained by the hospital or attending physici	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t	hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.
RECORDS, P.O. BOX 687	requires that the death certificate be executed	seen signed by the attending physician and co-	, of Health and Mental Hygiene prior to burial,
DIVISION OF VITAL	L OR ATTENDING PHYSICIAN: The law	DIRECTOR: After this certificate has b	hours after death with the State Dept,

ial-transit permit. Pages 1, 2, 3 should THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the moust after death. Page 6 may be retained by the hoss of the following physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.

WRORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / I	DEPARTMENT OF I		ENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) JOHNNIE MITCHELL			2. DATE OF DEATH DAY	YEAR 1	7:35 P M			
	4. SOCIAL SECURITY NUMBER 5. SEX 1. M 2 F 1. FACILITY NAME (If not institution, give street end number) 8. AGE (in yrs. last yrs. la	YRS. MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPI Country)	ACE (State or Foreign			
CTOR	REGENCY NSG AND REHAR CENTE	R FORES	TVILLE		PRINCE	GEORGES			
AL DIRECTOR	MARYLAND PRINCE GEORGES 10e. STREET AND NUMBER	OXON HIII				6d. INSIDE CITY LIMITS? YES 2 NO AT COUNTRY?			
BY FUNERAL	18.17 RRIFRFIFID ROAD 11. MARITAL STATUS 1 Never Married 2 Merried 3 1/2 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1/2 YES 2 NC	o if yes, s	20745 CENDENT OF HISPANIC pecify Cuben, Mexicen, 8 2 X NO Specify:	ORIGIN? (Specify Yee of Puerto Rican, etc.)	r No- 14. RACE -				
COMPLETED E	15. DECEOENT'S EDUCATION (Specify only highest grade completed) (Giv.	EEDENT'S USUAL OCCUPATI e kind of work done during m Do NOT use retired.)		16b. KIND OF BUSIN	HESS/INDUSTRY	BLACK			
OMP	6TH. DI	OMESTIC	18, MOTHER'S NAME	PRIVA					
BE C	HENRY LEWIS		2777	NN MITCHE	,	I.S.			
10		MAILING ADDRESS (Street 817 BRIFRE	end Number or Rural Ro	ute Number, City or Town,	State, Zip Code)				
	20e. METHOD OF DISPOSITION 1 Burlei 2 Cremention 3 Removal from State Cemetery, crem	ND DATE OF DISPOSITION (Netory or other place)		DATE 20c. LOCA	TION — City or Town	n, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME A E.M.	DUDLEY	FUNERAL		ER_MD20712			
	22-PART I. Entar tha diseases, or complications that caused the dea shock, or heert fellure. List only one ceuse on each line.	th. Do not entar the me	ode of dying, auch	as cardiac or reapira	tory erraat,	Approximate Interval Batween			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) RESPIRAT	ORY FAILUR	RE			ONE DAY			
CERTIFICATION		E METASTAT	TIC PROS	TATE CARC	CINOMA				
PHYSICIAN: MEDICAL O	PART II. Other significent conditions contributing to deeth but not re DYSPHAGIA HE WAS DNR	suiting in the underlying	ng ceuae given in Pa	24s. WAS AN AL PERFORM 1 YES 2	EO?	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N:					'	N/A			
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 N NO	OTHER:	LACE OF OEATH (Check						
PHY	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. IN	JURY AT ORK2	ted. OESCRIBE HOW INJ	URY OCCURED				
à	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	M 19	MES 2 NO	LOCATION (Street and	d Number or Burnt Do	do Mumboo			
ETED	4 Homicide detarmined building, etc. (Specify)			City or Town, State)	o Namber of Name Plot	ne Number,			
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
띪	29b. SIGNATURE AND TITLE OF CERTIFIER	0	D-3(1	ER 21	PAPRIL	Aonth, Day, Year)			
2		27) (Type, Print) LE ROAD, S	UITE220,	BOWIE, MD	. 2071	6			
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								





FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 95AR KAMIL MUSTAFA MOHAMED-NOUR 4:00P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Dey. Year) NOV 29,1959 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. AGE (In yrs, lest birthday) 8. BIRTHPLACE (State or Foreign 1 M 2 D F 231-51-4367 36 Nov SUDAN Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7200 MARTIN LUTHER KING HGWY LANDOVER PRINCE GEORGES RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George District Maryland Heights 1 X YES 2 NO attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Intal Hygiene prior to burial, cremation, or removal. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20747 <u>2735 Lorring Dr.</u> #103 USA BALTIMORE, MARYLAND 21215-0020
A hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indien, Black, White, atc. 1) Never Merried 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced **Black** 16a. DECEDENT'S USUAL OCCUPATION

Work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ventary/Secondary (0-12) College (1-4 or 8 +) Laundry Operator Laundry once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) notified at Mustafa Kadamala Gassam Nour BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Adil Salih 14122Autumn Dr,Centerville,Va 22020 e 20a. METNOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 1X Buriel 2 Cremetion 3 Removal from State Family Cemetery 4-20-95 Madani, Sudan ☐ Donation 8 ☐ Other (Specify) medical examiner 22. NAME AND ADDRESS OF FACILITY 411Kennedy St, N.W. 21. SIGNATURE-OP) FUNERAL SERVICE LICENSEE Universal Mortuary Washington, D.C 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. Liet only one cause on each line. cremation, or Interval Between **IMMEDIATE CAUSE (Final** Onset and Death other traumatic event, the disease Dr condition_ MULTIPLE INJURIES resulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF): prior to If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS s been signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? amy XXYES 2 NO TXX 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{2}'\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: certificate has be the State Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate ha hours after death with the State D EXAMINER? HOSPITAL: 1 🗆 Inpetient 2 🗆 ER/Outpetient 3 🗆 DOA 4 Nursing Home 3 Residence 3 XOther (Specify) AT SCENE 27. MANNER OF DEATH 28b. TIME OF 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 4/12/95 1400 1 YES 2 NO BY DRIVER-AUTO-AUTO-COLLISION 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is 8 Could not be COMPLETED 4 Homicide ROADWAY 7200 MARTIN LUTHER KING HOWY 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. HOSPITAL FUNERAL I WITHIN 72 h = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II ele of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and menner as stated. 296. SIGNATURE AND THREE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

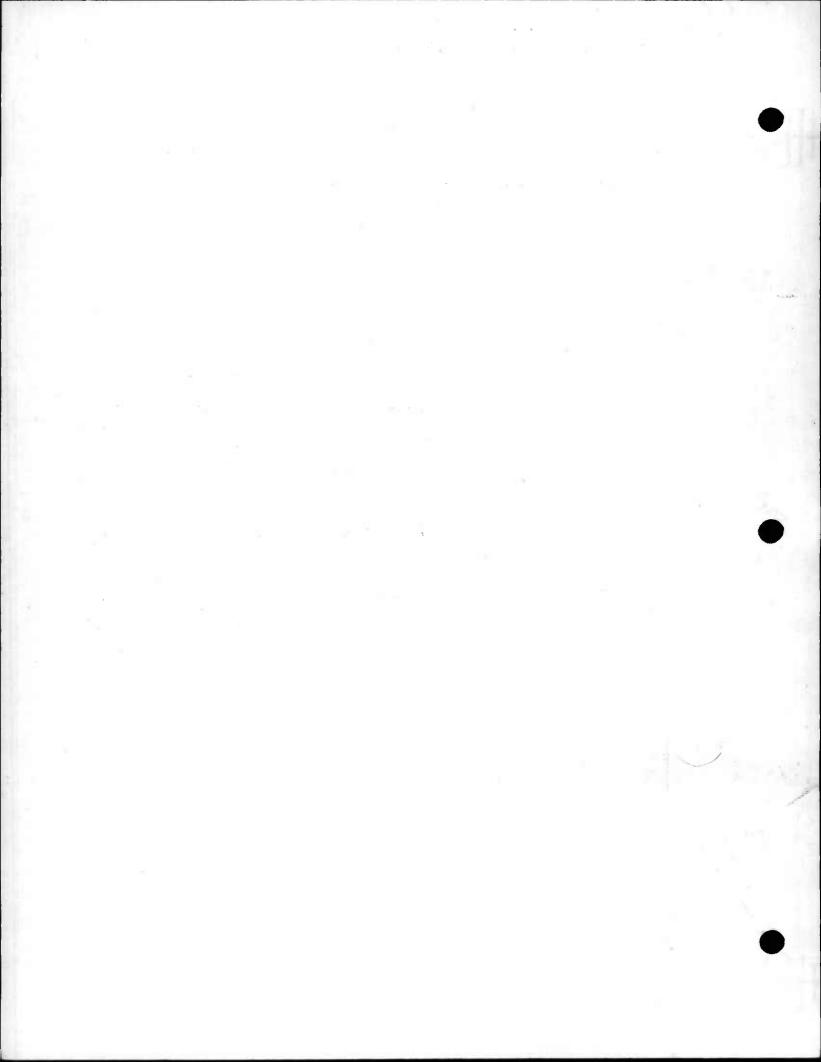
APRIL 13/95 BE O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID R. FOWLER 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Devoteor Karlal 4 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMN-18 Rev 1/89

	1. DECEDENT'S NAME (First,	, Middle, Last)	Feli	8		lejia	ICATE				2. DATE	REG. NO	-11		3. TIME OF DEATH
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DIRECTOR	10a. STATE	10b. COUNT	Υ			10c. CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY
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AL	10e. STREET AND NUMBER							101	. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
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Ę	11. MARITAL STATUS		12. WAS DECEDEN				13.	WAS DEC	ENDENT C	F HISPAN	IIC ORIGI	N? (Specify Yes	or No-	14. RACE	E — American India
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COMP	17. FATHER'S NAME (First, MI	iddle, Last)	***************************************		DISH WASHER			18. MOTHER'S NAME (First, Middle, Melden							
ш	JOSE ALBERT	O MEJ													
9 0	19e. INFORMANT'S NAME (7)	ype/Print)		196	. MAILING	AODRESS	(Street e	nd Number	or Rural F	Route Num	aber, City or Tow	n, State, Zij	p Code)		
7	VATIUIDAD M.	MEND	EZ	11	96. MAILING AODRESS (Street and Number of Rural L18 PATRICK STREET VI									0	
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	4 Donation 5 Other (Specify) FAMILY CEMETERY 4/18/95 EL SALVADOR											R			
	21. SIGNATURE OF FUNERAL SERVICE SERVICE 22. NAME AND ADDRESS OF FACILITY														
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SA REGISTRAR'S SIGNATURE



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

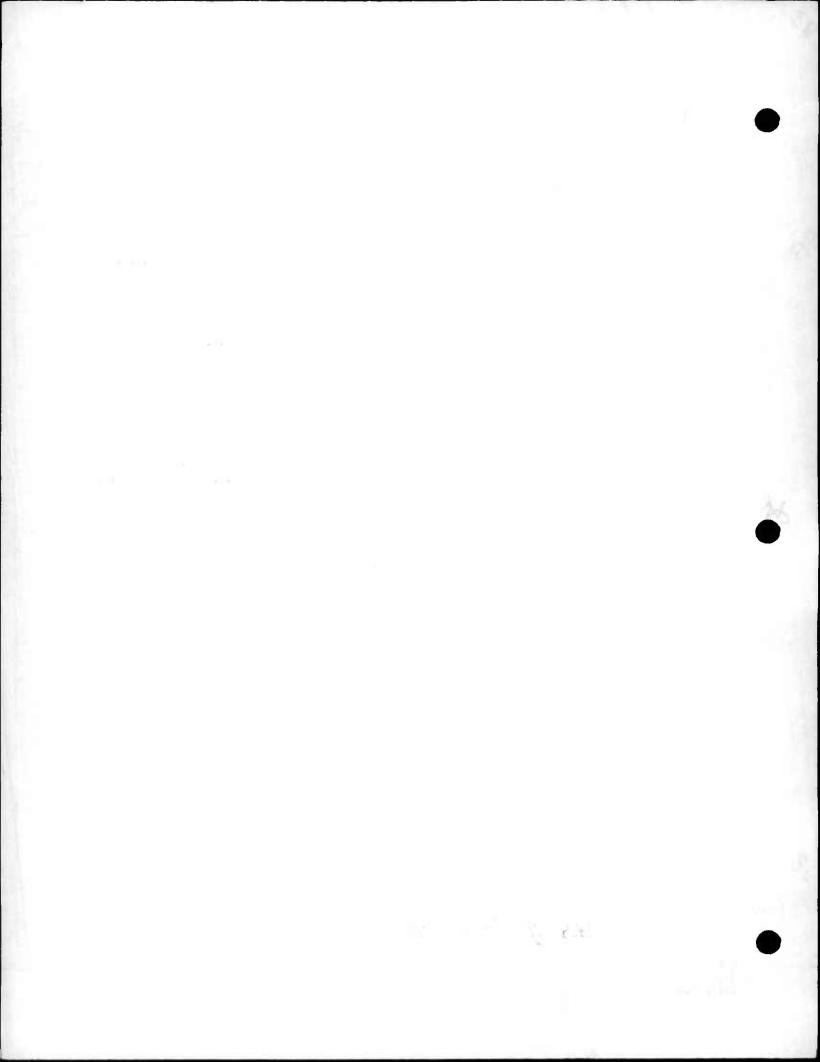
The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hydren prior to burial, cremation, or removal.

31. DATE FILED (Month, Day, Year)
APR 1 0 1995

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Java Dauchon Randell

	FOR CTATE OF	MADWAND ADDRESS			90 10002						
_	1 - STATE STATE UF		RIMENT OF HEALTH FICATE OF DEAT	AND MENTAL HYGIEN TH REG. NO							
	1. DECEDENT'S NAME (First, Middle, Last)	MCC	ATAL		DAY YEAR 3. TIME OF DEATH						
	CHARLIE H 4. SOCIAL SECURITY NUMBER 5. SEX	MCC B. AGE (In yrs. lest birthday	CAIN) IF UNDER 1 YEAR IF UNDER	APRIL 3	3 1995 9:00 P M 8. BIRTHPLACE (State or Foreign						
	252-26-329] 1 \(\overline{\text{M}}\) 2 \(\overline{\text{F}}\) 9a. FACRLITY NAME (If not institution, give street and number)	74 YRS.	MONTHS DAYS HOURS 9b. CITY, TOWN OR LOCATE	June 15, 19	20 South Carolina						
TOR	Prince George's Hospital Cente	er	Chever		Prince George's						
DIRECTOR	Maryland Prince George's		TY, TOWN OR LOCATION	pitol Heights	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO						
FUNERAL	410 Larchmont Avenue		10f. ZIP CODI	20743	10g. CITIZEN OF WHAT COUNTRY?						
₽	11. MARITAL STATUS 1 Never Married 2 Werried 3 Widowed 4 Divorced 12. WAS DECEDED FORCES? IF YES, GIVE	NT EVER IN U.S. ARMED YX YES 2 NO NAR OR DATES	13. WAS DECENDENT Of If yes, specify Cube 1 YES 2 X NO	F HISPANIC ORIGIN? (Specify Yen, Maxican, Puarto Rican, etc.) Specify:							
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT	S USUAL OCCUPATION work done during most of working	16b. KIND OF BU	JSINESS/INDUSTRY						
MPLET	Elementary/Secondary (0-12) College (1-4 or 5 12th grade	+) Ille. Do NOT	nt First Class		y (Retired)						
d at once.	17. FATHER'S NAME (First, Middle, Lest) Charlie Robert McCain		18. MOTE	Marylou Ha	n Sumame) ammond						
TO B	19a. INFORMANT'S NAME (Type/Print) Lillie Mae McCain (Wife)	19b. MAILIN 410 L	g ADDRESS (Street and Number archmont Avenue	or Rural Route Number, City or Tow Capitol Heights,	vn, State, Zip Code) Mary I and 20743						
must b	20a. METHOD OF DISPOSITION 1 DATE 20b. PLACE AND DATE OF DISPOSITION Name of the property DATE 20c. Location - City or Town, State State Comparison State Comparison State Comparison Compariso										
event, the medical examiner must be notified at	21. SIGNATURE OF THREFIAL SERVICE LICENSES	601		meratumome, Inc. Place, N.E. Wash	hington, D.C. 20019						
medical	23. PART i. Enter the diseases, Dr complications the	t caused the death. Do	not enter the mode of dyi	ng, such as cardiec or reep	Interval Between						
ant, the	iMMEDIATE CAUSE (Final disease or condition resulting in death)										
	Sequentially list conditions	OR AS A CONSEQUENCE OF	hafi	schen	ia freels						
or other traumatic	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OR AS A CONSEQUENCE	4		Vruel.						
y, or other traumatic	that initiated eventa resulting in deeth) LAST	(OF AS A CONSEQUENCE O	SF):								
흥그	PART II. Other aigniticent conditions contributing to	deeth but not recuiting	in the underlying ceuee g	iven in Part i. 24a. WAS AN	AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO						
EDICA				1 □ YES 2	COMPLETION DE CAURE						
3 shows N: MEE	DID TOBACCO USE CONTRIBUTE TO CA	USE OF DEATH Y	ES NO UNC	ERTAIN 🗆	1 TES 2 TXNO						
~ 4	25. WAS CASE REFERRED TO MEDICAL		ATH (Check only one)								
	1 YES 2 NO topatient 2	ER/Oulpetlant 3 🗆 DOA	OTHER: 4 Nursing Home 5 Re	sidence 6 - Other (Specify)							
marked, or BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending (Month, E		ME DF JURY 28c, INJURY AT WORK? 1 YES 2	NO 26d. DESCRIBE HOW I	INJURY OCCURED						
28 is TED	3 Suicide 6 Could not be 4 Homicide determined	F INJURY — Al home, farm, alc. (Specify)	street, factory, offica	261. LOCATION (Street City or Town, State)	and Number or Rural Route Number,						
월	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of a MEDICAL EXAMINER: On the bests of a										
PORTANT: IF	29b. SIGNATURE AND TITLE OF CENTIFIER			HSE NUMBER	294, DATE SIGNED (Morit), Dog May						
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Origin)											

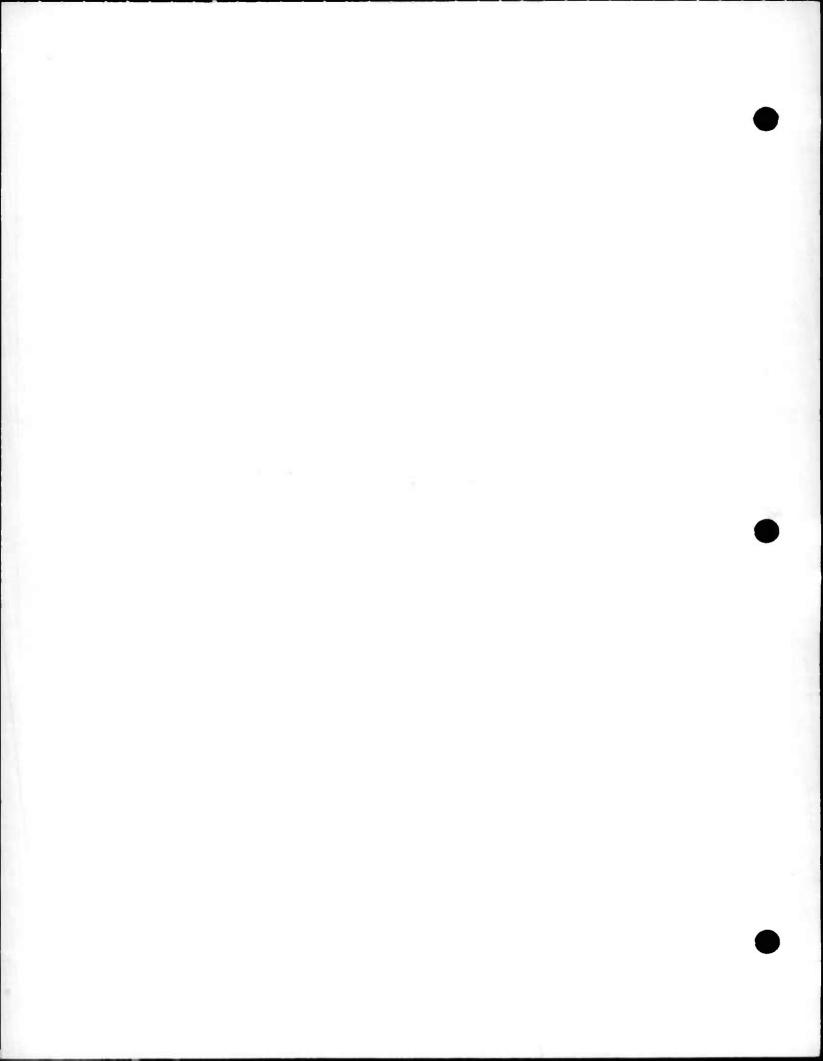


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31. OATE FILEO (Month, Day, War)
APR 2 0 1995

		1 - STATE REGISTRAR	STATE OF MAR	IYLAND / Ci	DEPARTME	NT OF H	HEALTH AND	MENTA	REG. NO.	E		
	5	1. DECEDENT'S NAME (First, Middle	, Last)			-			OF DEATH		3.	TIME OF DEATN
		DIANA	LYNN	M	CCORMIC	Χ		Apr	il 16,	1995	EAR 1	0:00 A
P.		4. SOCIAL SECURITY NUMBER 236-80-5042	1 🗆 M 2 💢 F	AGE (In yrs. Inc 44	YRS. WONTH	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7 DAYE	OF BIRTH 19, 19	950	BIRTHPLA Country)	CE (State or Foreign
2, 3 should	стоя	9a. FACILITY NAME (If not institution MEMORIAL HOSP	ITAL	Ÿ		ITY, TOWN O	OR LOCATION OF D			9c. COUNTY	GANY	
	І ш	1 10a. STATE 10b. COUNTY									10.	1. INSIDE CITY
permit. Pages	DIR	MD A	llegany		Littl	e Orl					1 [LIMITS?
\$	FUNERAL	Route 1 Box 8					21766			USA	N OF WHAT	COUNTRY?
-AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once.	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	Never Married 2 Merried FORCES? 1 YES 2 N			If yes, sp	CENDENT OF HISPA Hecity Cuben, Mexic is 2 (2)-NO Speci	an, Puerto I		or No- 14	Specify:	American Indian, hite, etc.
r attend use as	윤	15. DECEDENT (Specify only highes	'S EDUCATION It grade completed)	16a. DE	CEDENT'S USUAL	OCCUPATION OF	ON set of weeking	16b	KIND OF BUS	INESS/INOUS	TRY	
the hospital or detached for a	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		ive kind of work do Do NOT use retired Omemake:		at or norming		Own H	ome		
3 2 E	l w l	17. FATNER'S NAME (First, Middle, La Dale B. Sig	pes				16. MOTNER'S N. Hele	AME (First, I		Sumame)		
retained by 5 should be notified at	5 B	19e. INFORMANT'S NAME (Type/Print					and Number or Rural					
	-	Dale B. Sipes		H:	igh Gern	nany 1	Road Lit	tle C			_	
rector,		20a, METHOD OF DISPOSITION 1 & Buriel 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cometery, cre Mart	and date of disp matory or other place in Cemet	osition (Na :e) :ery	arne of	04/		ttle C		ns, MD
ALIIN death. Pag tuneral di i. examiner		21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE		1 (2	SCATT	oelli Fu	neral	Home		-	
BAL ter dear the fun wal.		James	7 8/Ca)	DO		Cumbe	erland,	MD 2	21502			
		23. PART I Enter the disease shock, or heart fa	a, or complications that cau- llure. List only one cause o	sed the de	ath. Do not ant	er the mo	ds of dying, su	ch aa card	llac or reapir	ratory arreal	t,	Approximata
filled in b fon, or rer		IMMEDIATE CAUSE (Final	and only one cause o	II OMOII IIIIQ	•						Ì	Onsat and Deat
> = =		disease or condition	4 . 35	1	· 1 - C							1 hour
mplete crem,	1 1	resulting in deeth)	. Acute My			arcti	on					
uted within completely fille intal, cremation, it event, the	2	resulting in deeth)	DUE TO (OR /	AS A CONSE	DUENCE OF):		on					
os / os / os and com burial, natic en	TION	Sequentially list conditions, if any, leading to immediate		Arte	ry Disea		on					2 years
be executed cian and corror to burial, caumattic ex	ICATION	Sequentially list conditions,	Coronary Due to (on A Diabetes	Arte As a consec Mell	ouence or: ry Disea ouence or: itus		on					
C. DOA OST. certificate be executed fing physician and com ygiene prior to burial, other traumatic ex	TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. Coronary DUE TO (OR A C. Diabetes DUE TO (OR A	Arte Arte As a consec Mell As a consec	ouence or: ry Disea ouence or: itus		on					2 years less than 20 years less than
th certificate be executed ending physician and com Hygiene prior to burial, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b. Coronary DUE TO (OR A DIABETES DUE TO (OR A d. Sclerode	Arte Arte As a consec Mell As a consec rma	DUENCE OF: TY Disea DUENCE OF): itus DUENCE OF):	ise						2 years less than 20 years
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at the death certificate be executed by the attending physician and coming Memail Hygiene prior to burial, if Injury, or other traumatic or	MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b. Coronary Due to (on A c. Diabetes Due to (on A d. Sclerode ditiona contributing to deat	Arte Arte As a consec Mell as a consec rma	TY Dises TY Dises DUENCE OF): itus DUENCE OF): esulting in the	ase underlying	g cause given in		PERFORI	MED?	24b. WEI	2 years less than 20 years less than 5 years
L. TECOLDS, F.O. DOX 606.18 law requires that the death centificate be executed as registed by the attending physician and combet; or Health and Mental Hygiene prior to burial. 23 shows any Injury, or other traumatic or	MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the condition	b. Coronary DUE TO (OR A c. Diabetes DUE TO (OR A d. Sclerode ditional contributing to deat	Arte Arte As a consec Mell As a consec rma th but not r	TH YES	ase underlying	g cause given in		PERFORI	MED?	24b. WEI	2 years less than 20 years less than 5 years name prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior to present the prior the p
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TISTOR OF VITAL PECOLDS, F.O. DOA 68 REPORTED STATES OF THE WASHINGS THAT THE law requires that the death certificate be executed TIDE. After decificate has been signed by the attending physician and confaire death with the State Dent. of Health and Mental Hygiene prior to burial. 28 is marked, or item 23 shows any injury, or other traumatic or	D BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificent con DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	DUE TO (OR A Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A d. Sclerode ditiona contributing to deat DNTRIBUTE TO CAUSE The impatient 2 = ERVC (Month, Day, Not put to the	Arte Arte As a consec Mell As a consec rma th but not r COF DEA 28. PLAC Outpatient 3 RY BRY BRY BRY BRY BRY BRY BRY BRY BRY	TH YES THE OF DEATH (Check of Injury M	NO Lick only one) ER: uraling Nom 28c. INJ 28c. INJ	UNCERTAL 5 Realdence URY AT PKS 2 NO	8 Other	PERFORI 1 YES 2	MED? NO NO	24b. WEI AMA COO OF 1	2 years less than 20 years less than 5 years RE AUTOPSY FINDINGS ILABLE PRIOR TO APPLETION OF CAUSE DEATH? YES 2 \(\) NO
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LOST OF THE ALL DECORDS, F.O. DOA 60 R.A. LORGING BY STEADING PHYSICIAN: The law requires that the death certificate be executed. LORGING A recentificate base seen signed by the attending physician and control programmers after death with the State Dept. of Health and Mental Hygiene prior to burial if item 28 is marked, or Item 23 shows any injury, or other traumatic or	COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST PART II. Other eignificent con DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending Investigation of Suicide 8 Could in determined to the control of the control o	DUE TO (OR A DIABETES DUE TO (OR A C. Diabetes DUE TO (OR A D. Sclerode ditional contributing to deat DIABETE TO CAUSE THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: THOSPITAL: Thospital 2 = ER/C 28a. DATE OF INJU 28a. DATE OF INJU AMINER: On the best of my known to be need.	Arte Arte As a consec Mell As a consec rma Corporation of recommendate of the second	TH YES THE OF INJURY MENTS of the occurred at the strong process of the strong process o	NO Leck only one) ER: unsing Nom 28c. INJ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	UNCERTAL TO S Residence UNY AT RK7 YES 2 NO end plece, and due esth occured at the	8 Other 28d. DES 28f. LOCK Chy 6	PERFORI 1 VES 2 T (Specify) CRIBE HOW IN ATION (Street ar Town, Stete)	JURY OCCUR	24b. WEI AMA COO OF 1 C	2 years less than 20 years less than 5 years less than 6 years years LABLE PRIOR TO APPLETION OF CAUSE DEATH? YES 2 NO
OR ATENDING PHYSICIAN. The law requires that the death certificate be executed OR ATENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and control and the cast with the State begt, of Health and Mental Hygiene prior to burial tem. 28 is marked, or Item 23 shows any Injury, or other traumatic en	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events reaulting in death) LAST PART II. Other eignificent con DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1	DUE TO (OR A COTONARY DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A SCIerode ditional contributing to deat DIABETE TO CAUSE LE INTERPOLITAL: 1 E inpettent 2 = ER/C SEA. DATE OF INJUI Contribution 28e. PLACE OF INJUI Duilding, etc. (3) PNYSICIAN: To the baset of my kn AMMINER: On the basel of examinations THERE	Arte Arte As a consec Mell As a consec rma th but not r Cof DEA 26. PLAC Outpatient 3 RY Br) URY — At ho Specify) nowledge, de ation and/or i	DUENCE OF: TY Disea DUENCE OF: Itus DUENCE OF: COUNTY The county E OF OEATH (Check DOA 4 N 20b. TIME OF INJURY Mene, farm, street, father occurred at the investigation, in my	NO Leck only one) ER: unsing Nom 28c. INJ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	UNCERTAL BE 5 Realdence URY AT YES 2 NO end plecs, and due	8 Other 28d. DES 28f. LOCK Chy 6	PERFORI 1 VES 2 T (Specify) CRIBE HOW IN ATION (Street ar Town, Stete)	JURY OCCUR	24b. WEI AMA COO OF 1 C	2 years less than 20 years less than 5 years less than 6 years lable prior to pretion of cause death? Yes 2 \(\) No
LOST OF THE ALL DECORDS, F.O. DOA 60 R.A. LORGING BY STEADING PHYSICIAN: The law requires that the death certificate be executed. LORGING A recentificate base seen signed by the attending physician and control programmers after death with the State Dept. of Health and Mental Hygiene prior to burial if item 28 is marked, or Item 23 shows any injury, or other traumatic or	E COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST PART II. Other eignificent con DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of Suicide 8 Could in determined to the Company one) 29a. CERTIFIER (Check only one) 29b. SIGNATUSE AND TITLE OF CERTIFYING (Check only one) 30. NAME AND ADDRESS OF PERSON	DUE TO (OR A COTONARY DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A C. Diabetes DUE TO (OR A SCIerode ditional contributing to deat DIABETE TO CAUSE LE INTERPOLITAL: 1 E inpettent 2 = ER/C SEA. DATE OF INJUI Contribution 28e. PLACE OF INJUI Duilding, etc. (3) PNYSICIAN: To the baset of my kn AMMINER: On the basel of examinations THERE	AT TE AS A CONSECT ME 11 AS A CONSECT ME 11 AS A CONSECT ME 11 AS A CONSECT ME 11 AS A CONSECT ME 12 AS A CO	TH YES THE OF INJURY MENT OF INJURY	NO Leck only one) ER: unsing Nom 28c. INJ actory, office	UNCERTAL OF 5 Realdence URY AT FES 2 NO end plecs, and due eith occured at the 29c. LICENSE NU D23371	3 Other 28d. DES 28f. LOC/Chy of	PERFORI 1 YES 2 T (Specify) CRIBE HOW IN ATION (Street at a r Town, State) se(e) and mann and place, and	NO NO NO NO NO NO NO NO NO NO NO NO NO N	24b. WEI AMA COO OF 1 C	2 years less than 20 years less than 5 years less than 6 years years LABLE PRIOR TO APPLETION OF CAUSE DEATH? YES 2 NO

32 REGISTRAR'S SIGNATURE



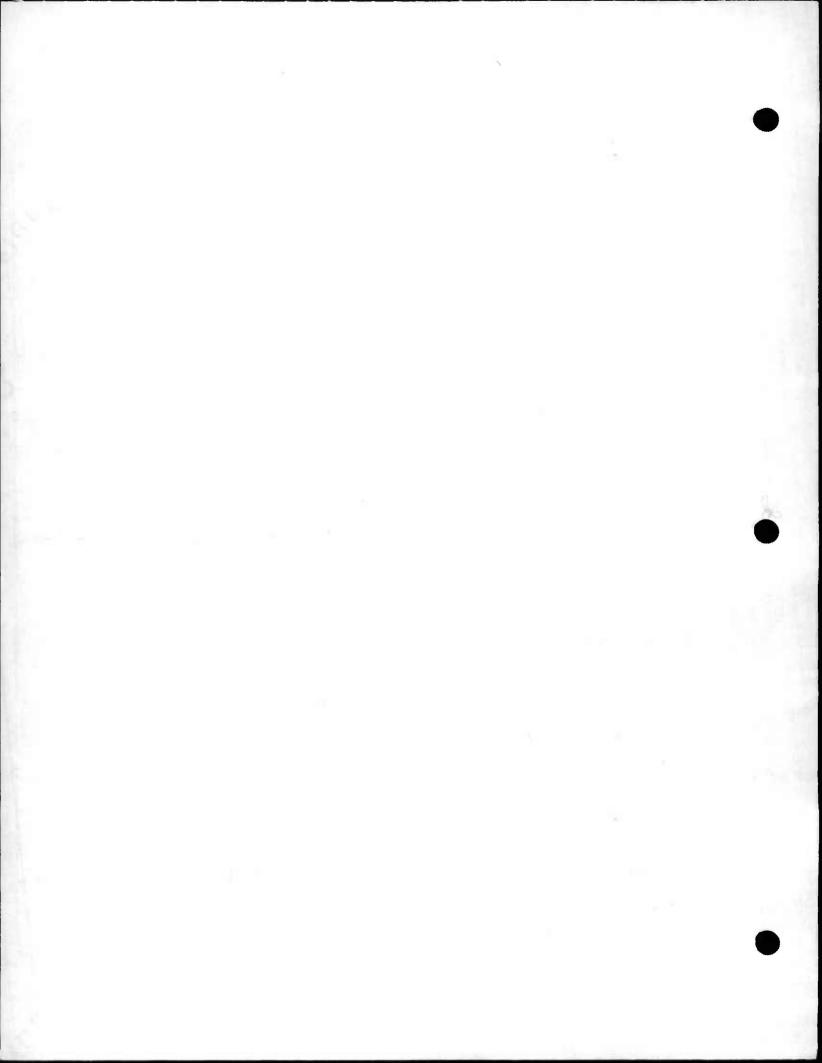
REGISTRAR		CERTIF	ICALE O	L DEALH	REG. NO	O.			
1. DECEDENT'S NAME (First, Middle, Last) DENNIS	FRANKLIN		MANSP	EAKER		7, 1995	3. TIME OF DEATH 05:05 A		
4. SOCIAL SECURITY NUMBER 165-24-5652	5. SEX 8. AGE (In yr	rs. last birthday) YRS.	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign intry)		
	98. FACILITY NAME (If not institution, give street and number)				Mar 9, 1924				
SACRED HEART HO			96. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND 9c. COUNTY OF DEATH ALLEGANY						
10. STATE 10. COUNTY									
MD Allegany Cumberland							10d. INSIDE CITY LIMITS? 1 YES 2 NO		
11 Blackiston Av	venue			21502		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES WW TT	. □NO	If yes,	DECENDENT OF HISPA specify Cubsn, Mexic (ES 2 X NO Spec	ANIC ORIGIN? (Specify Yosan, Puerto Ricen, etc.)	Bi	CE — American Indian, ack, White, etc.		
15. DECEDENT'S EDU (Specify only highest grade	JCATION 16	. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BI	USINESS/INOUSTRY	willte		
Elementary/Secondery (0-12)	College (1-4 or 5 +)	IIIe. Do NOT u	work done during se retired.) ed Print		Novemen	nanor.			
17. FATHER'S NAME (First, Middle, Lest)		INCLIE	d IIII		Newsp AME (First, Middle, Melde				
James Manspea	ker				a (Shinn)	ii Gomerney			
19e. INFORMANT'S NAME (Type/Print)	1102	19b. MAILING	AODRESS (Stre		A (SIIIIII) Route Number, City or To	um State 7in Codel			
Louise A. Manspe	pakor						1500		
246 METHOO OF DISPOSITION	20h BI		OF DISPOSITION		Cumberlan	O. MD Z			
1 Buriel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	noval from State	a oromotom or o	chas almost	•	± 04/19 Ye				
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE /	Pauls	22. NAME	AND ADDRESS OF	F D#\ID IE	STIOM CLE	ex, PA		
Scarpelli Funeral Home Cumberland, MD 21502									
23. PART I/Enter the diseases, or	complications that caused th	e danth. Do i	not antar tha	mode of dying, au	ch se cardiac or real	piratory srrest,	Approximate		
MANAGOLATE CALLOE (Final	List only one cause on each						intarval Batwee		
disease or condition	· mitaste	Tin	Cul	en Co	5		11200		
reaulting in death)	DUE TO (OR AS A CO	NSEQUENCE O	F):		and a		- Guer		
	h						1		
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUENCE O	F):						
cause. Entar UNDERLYING CAUSE (Disesse or injury	c								
that initiated events	OUE TO (OR AS A CO	NSEQUENCE O	F):						
reaulting in death) LAST	d								
PART II. Other significant condition	na contributing to death but a	not regulting	In the underly	dag seuse alves t	Book I as supply				
	The south Dating to death Datin	Tot resulting	in the directly	ang cause given ii	Part i. 24s. WAS AI PERFO	RMEO?	Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
						2	1 YES 2 NO		
DID TOBACCO USE CONT	RIBUTE TO CAUSE OF D	DEATH YE	S NO	UNCERTA	N 🗆				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28.1 HOSPITAL:	PLACE OF DEAT	TH (Check only or	10)					
	1 Inpetient 2 ER/Outpatier	nt 3 🗆 DOA	OTHER: 4 - Nursing H	oma 5 🗆 Residence	6 Other (Specify)				
1 TYES 2 NO	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		NJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURED			
27. MANNER OF DEATH				YES 2 NO					
27. MANNER OF DEATH 1 Netural 5 Pending	(MOTALL, Day, 16E7)			J . 20 2 1 10					
27. MANNER OF DEATH 1 Natural 5 Pending	28e. PLACE OF INJURY — Abuilding, atc. (Specify)	At home, term, s			28t. LOCATION (Street City or Town, Stete	end Number or Rura))	I Route Number,		
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) CERTIFYING PHYS	28e. PLACE OF INJURY — A building, stc. (Specify)	e, death occurr	street, tectory, of	fice	City or Town, Stete	Priner es atated.			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	28e. PLACE OF INJURY — A building, etc. (Specify) PICIAN: To the best of my knowledge ER: On the basis of examination end	e, death occurr	street, tectory, of	fice	City or Town, Stete	Priner es atated.			
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) CERTIFYING PHYS	28e. PLACE OF INJURY — A building, etc. (Specify) PICIAN: To the best of my knowledge ER: On the basis of examination end	e, death occurr	street, tectory, of	fice	e to the ceuse(s) end me	nner es atated.			
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. PLACE OF INJURY — A building, stc. (Specify) CICIAN: To the best of my knowledge ER: On the basis of examination end R	e, death occurre	street, tectory, of ed at the time, d m, in my opinion	fice are and place, end du , death occured at th	e to the ceuse(s) end me	nner es atated.	r(s) end manner es stated.		
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WH	28e. PLACE OF INJURY — A building, etc. (Specify) BICIAN: To the best of my knowledge ER: On the bests of examination end R	e, death occurred/or investigation	street, fectory, of and et the time, d in, in my opinion	ate and place, and du , death occured at th 29c. LICENSE NU 29 C. LICENSE NU	e to the ceuse(s) end me o time, date end piace, a	onner es atsted. Ind due to the cause 29d. DATE SIGNE APRIL	r(s) end manner es stated.		
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. PLACE OF INJURY — A building, etc. (Specify) BICIAN: To the best of my knowledge ER: On the bests of examination end R	e, death occurred/or investigation (ITEM 27) (Type,	street, fectory, of and et the time, d in, in my opinion	ate and place, and du , death occured at th 29c. LICENSE NU 29 C. LICENSE NU	e to the ceuse(s) end me o time, date end piace, a	onner es atsted. Ind due to the cause 29d. DATE SIGNE APRIL	r(s) end manner es stated.		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020



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TO THE MOSTIAL OF ALL ENDING PHYSICIAM: THE LAW FEQUITES THAT THE GRAIN CERTIFICATE BE EXCLUDED WITHIN MOUTS After death. Page 6 may be retained by the hospital or attending physician.
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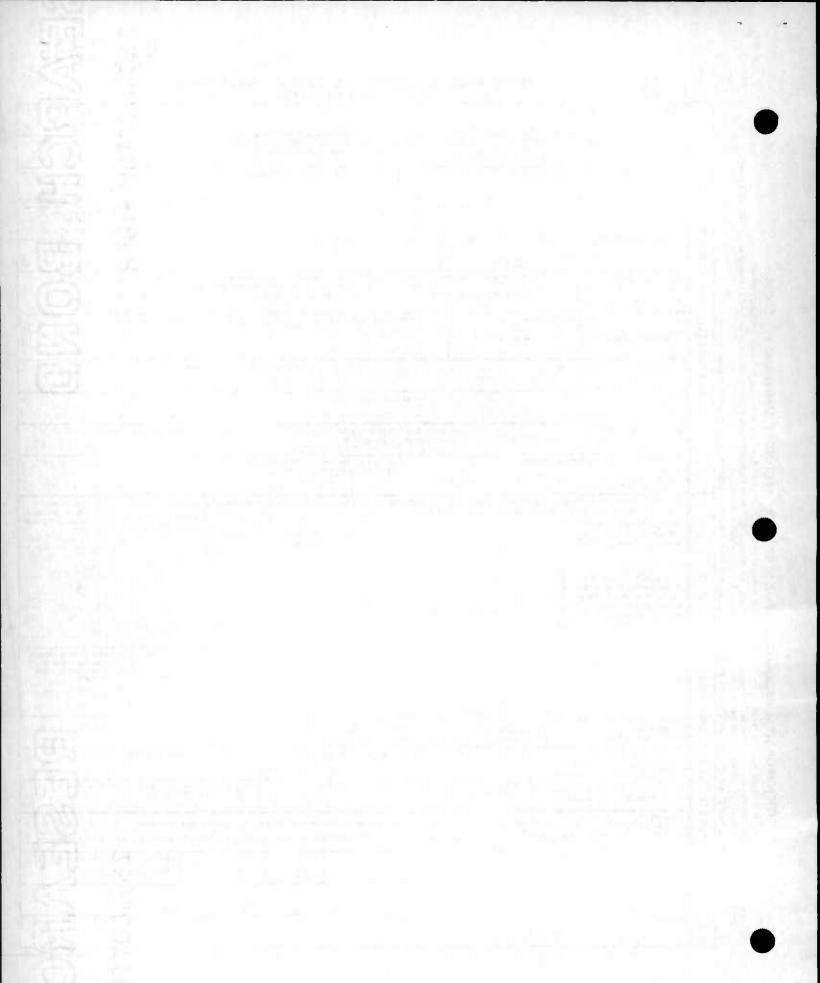
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	FOR	CTATE OF MA	DVI AND /	DEDAE	714-11	T 05 11	5 4 1 7 1 1					U	10000
	1 - STATE REGISTRAR	STATE OF MA					DEAT		MENIAL	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)						DEA	-	2. DATE	OF DEATH			3. TIME OF DEATH
	Margaret	w.	H	zva	10				MONTH 나	1 0		YEAR	N6 18/Am
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las		70-00	R 1 YEAR	IF UNDER	24 HRS.	7. DATE C	F BIRTH	0	S. BIRTI	HPLACE (State or Foreign
	217-50-1703	1 🗌 M 2 💢 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.		10.1	906	Count	Marvland
	9a. FACILITY NAME (If not institution, give si	treet and number)			9b. CIT	Y, TOWN C	R LOCATIO	ON OF DE		1001	-	JNTY OF E	Al .
OR	Montgomery Gene	ral Hospi	tal				Olne	v			Mo	onte	omery
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			_								00	
H				10c. CIT	Y, TOWN	OR LOCAT							10d, INSIDE CITY LIMITS?
	Maryland Car	rroll		<u> </u>			Air	U					1 X YES 2 NO
FUNERAL		ville Roa	a			101	ZIP CODE	771					WHAT COUNTRY?
NE.	11. MARITAL STATUS	12. WAS DECEDENT E		MED	140	WW C DEO		1 1 -	110 OD10111				States
	1 Never Married 2 Merried	FORCES? 1	YES 2 AN	Ю	13.	If yes, spe	clty Cubar	, Maxice	n, Puerto R	(Specify Yealcan, etc.)	or No-	14. RAC Blac	E — American Indian, k, Whita, efc.
ВУ	3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES			1 YES	2Å∏ NO	Specify	y:			Spec	White
B	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16e. DE	CEDENT'S	USUAL C	CCUPATIO)N		16b.	KIND OF BU	SINESS/IN		
Ē	Elementary/Secondery (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)	auring mo:	st of working	9					
MP	4			Hon	nema]	ker				Own	Home	Э	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-					18. MOTH	ER'S NA	ME (First, M	iddle, Maiden	Surname)		
BE	John Po	ole						C	lara	Grime	S		
2	19e. INFORMANT'S NAME (Type/Print)		19b							er, City or Tow			
	Dorothy V. Hal	1		201	Wate	ersvi	lle	Road	d, Mt	.Airy	, Md	. 21	771
	20e. METHOD OF DISPOSITION 1 \(\bigcap \) Buriel 2 \(\bigcap \) Cremetion 3 \(\bigcap \) Remote 4 \(\bigcap \) Donation 5 \(\bigcap \) Other (Specify)	oval from State	20b. PLACE A cemetery, cree Jeni	nd DATE	ther place	sition (Na	ne of Ceme	ter	/21°/9	51	CATION -		own, State Md .
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1	3-4-1-5 K	22.	NAME AN	D ADDRES	S OF FA	CILITY			ence	nu.
1	Dh: 4	W.l.	the	;						h, P.		263	00000
-	23. PART i. Entar the disesses, pro	nmpleations that c	sused the de-	eth Do r	Dt ente	2040	L KILO	ige i	ка.,	Damas	cus,	Md.	20872
	shock, or heart failura.	List Dnly one csuse	Dn esch ilne.		ibt eme	trie ino	ue Di dyii	ng, suci	n as esroi	sc or respi	ratory ar	rest,	Approximate interval Between
	iMMEDIATE CAUSE (Finsi disease or condition	D .	-		0	1							Onset and Death
	resulting in death)	a. Kespi	AS A CONSEC	UENCE OF	7.	Lev	10_						2 day
z		Abdo	HPN	0	11	ے کا ن	, . ().		d	130	n = 0	1	6/1
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OF	AS A CONSEC	UENCE O	7: 0	C	1					1	Carro
CA	cause. Entar UNDERLYING CAUSE (Disesse or Injury	· Duode	nal	10	ref.	ni	les	~i					
片	that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEC	UENCE OF	7: C								
H	rossking in death) EAST	ś											
- 1	PART II. Other significant condition	s contributing to da	ath but not re	sulting	n the u	nderlying	csuse g	lven in	Part t,	24a. WAS AN	AUTOPSY	248	. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL										PERFOR	_		AMILABLE PRIOR TO COMPLETION DF CAUSE
									_	1 TYES 2	NO		OF DEATH?
-	DID TOBACCO USE CONTE	RIBUTE TO CAUS	SE OF DEAT	TH YE	s 🗆	NO 🗆	UNC	ERTAIN	v n l			ı	To tes 2 Ino
M	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT					<u>, </u>				
Sic	EXAMINER?	HOSPITAL:	VOutpetient 3	□ DOA	OTHE		5 🗆 Rec	dence	6 🗆 Other	(Specify)			
Ť	27. MANNER OF DEATH	28e. DATE OF INJ (Month, Day,		28b. TIM		28c. INJU	JRY AT			RIBE HOW I	NJURY OC	CURED	
BY	1 Netural 5 Pending 2 Accident Investigation	(М		ES 2	NO					
E	3 Suicide 8 Could not be	26e. PLACE OF IN building, etc.	IJURY — At hor (Specify)	na, ferm, s	treet, fec	tory, office			281. LOCA	TION (Street of Town, State)	nd Numbe	r or Rumi i	Route Number,
	4 Homicide determined												
2	29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, des	th occurre	d at the t	ime, data	end placa,	and due	to the caus	e(e) end mer	iner se sta	ted.	
COMPLET	one) 2 MEDICAL EXAMINE	3: On the basis of axem	ination end/or in	rvestigstio	n, in my o	opinion, de	eth occure	d at the	time, date e	nd plece, an	d dun to ti	ha cause(e	e) end menner se stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	2 /	10				29c. LICEI	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
B C	author 7.10	0-10.1	(1)				DZ	41	90	i	•	4/18	3/95
임	30. NAME AND ADDRESS OF PERSON WHO Arthur F. Woodwa	completed cause of	OF DEATH (ITEM	27) (Type,								1	()
	# 205 3416 C	Dhandwoo		t	0	Lave	4 1	nd	2	083	2		
- 1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE										

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		rmit. Pages 1,
BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	y filled in by the funeral director, page 5 should be detached for use as the burial-transit pages of comments
DIVISION OF VITAL RECORDS, P.O. BOX 68760, A BALTIMORE, MARYLAND 21215-0020	L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, bears after death with the Crise Dear of Health and Mental Historian prior to burial commander or sementing or sementing or sementing.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1. DECEDENT'S NAME (First, Middle,			CATE OF DEATH	2. DATE OF DEATH		3. TIME OF DEATH
		l C. Miller			April 26	1995	11:24
	4. SOCIAL SECURITY NUMBER 276-20-4328	1 □ M 2 💢 F	93 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 8,	1902 Io	
CTOR	90. FACILITY NAME (# not institution, Lorien Nursing	g Home		9b. CITY, TOWN OR LOCATION OF CO.	EATH	9c. COUNTY OF HOWA	None and
ECT	10e. STATE 10b. C	COUNTY	10c. CITY	, TOWN OR LOCATION			10d. INSIDE CITY
DIRE		Howard	I	Highland		200	1 VES 2 NO
ERAL	100. STREET AND NUMBER 6547 River Cly	udo Drivo		101. ZIP CODE 20777		May 1-6-3 1	F WHAT COUNTRY?
FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER	3 2 NO	13. WAS DECENDENT OF HISPA It yes, specify Cuban, Maxic 1 YES 2 NO Speci	en, Puerto Rican, etc.)	e or No- 14. RA Bit	d States American Indian, ack, White, atc. acity:
D BY	3 Midowed 4 Divorced	'S EDUCATION	16. DECEDENT'S	USUAL OCCUPATION	165 KIND OF BU	SINESS/INDUSTRY	White
ETE.	(Specify only highes Elementary/Secondary (0-12)	t grade completed) Coflege (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during most of working	IOS. KIND OF BU	SINESS/INDUSTRY	
COMPL			Teach				ol System
E CO	17. FATHER'S NAME (First, Middle, La Albert F. Cl				AME (First, Middle, Meiden		
O BE	19s. INFORMANT'S NAME (Type/Print		19b. MAILING	ADDRESS (Street and Number or Rural	T. Thorr Route Number, City or Tow		
۲	Ms. Tecla Jas			River Clyde Dri			
	28e. METHOD OF DISPOSITION 1 Burlel 227 Cremation 3 4 Donation 5 Other (Specify	Removal from State	D. PLACE AND DATE O	F DISPOSITION (Name of her place) 1. Crematory 7	DATE 20c. LC	CATION - City or	Town, State
	21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE	Bart-wasi	22. NAME AND ADDRESS OF F	CILITY		
	1 Stan Cons	M. Lewn	er	Harry H Witzl			
	23. PART I. Enter the disease ahock, or heart fe iMMEDIATE CAUSE (Finel disease or condition resulting in death)	liure. List only one ceuse on	each line.	ot enter the mode of dying, au	ch aa cerdlac or reap	ETTICOT:	Approximate interval Betv Onset and D
RTIFICATION	ahock, or heart fe iMMEDIATE CAUSE (Fine) disease or condition	a. Premunia DUE TO (OR AS C. DUE TO (OR AS	each line.	Delydation - Alalumus's	ch aa cerdlac or reap	EIIICOT:	Approximate interval Bets Onset and D
AL CERTIFICATION	ahock, or heart fe iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Prewmind DUE TO (OR AS b. Sevent D DUE TO (OR AS c. DUE TO (OR AS d	A CONSEQUENCE OF	Delydation - Alalumus's	type	I AUTOPSY 2.	Approximate interval Betwoen and D T week
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) ROS	ALIE -	(N	IARSHALL)	2. DATE OF DEATH MONTH DAY	Y YEAR 3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 215-20-4443 98. FACILITY NAME (If not institution, give st	1 □ M 2 💢 F	yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. IONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCt. 9, 19	918 BIRTHPLACE (State or Foreign Maryland		
TOR	PENINSULA REGION	A CONTRACTOR OF THE CONTRACTOR		SALISBURY	DEATH	9c. COUNTY OF DEATH WICOMICO		
DIRECTOR	10a. STATE 10b. COUNTY Maryland Somerset			TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO		
FUNERAL	100. STREET AND NUMBER 27338 Cash Corner	Road	•	101. ZIP CODE 21.	817	10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN 1 FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	13. WAS DECENDENT OF HISP II yes, specify Cuben, Mexi- 1 YES 2 NO Spec	ean, Puarlo Rican, etc.)	or No- 14. RACE — American Indian, Black, White, atc. Specify: White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) Grade 8	College (1-4 or 5+)	(Give kind of wo life. Do NOT use	SUAL OCCUPATION rk done during most of working retired.)	Mrs. Pat	INESS/INDUSTRY		
00	17. FATHER'S NAME (First, Middle, Last)				IAME (First, Middle, Maiden S	iumame)		
BE	Ira Thomas 190. INFORMANT'S NAME (Type/Print)		19b. MAILINO A	DDRESS (Street and Number or Rura	da Webster	State Zin Code)		
5	Kenneth M. Marshal	1 (Husband)	1	Cash Corner Rd				
	20e. METHOD OF DISPOSITION 1 Strict Burlel 2 Cremation 3 Remo	val Irom State cemel	ery cremetory or other	DISPOSITION (Name of proface)		CATION — City or Town, State		
	21. SIGNATURE OF FUHERAL SERVICE LIC	I Sur	<u>inyriage</u>	Memorial Park-	ACILITY	risfield, MD		
	Robert H. Brad	shaw. Jr.	1	Bradshaw & S		Home eld, MD 21817		
	23. PART i. Enter the diseases, or c abock, or heart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that caused it.	th line.	lanter the mode of dying, su	ch as cardiac or respin	Approximata Interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A C	u O	Gyo carolial on onay (1)	Infarct	ear tyrs.		
CERTII	that initiated events reaulting in death) LAST	DOE TO JOHN AS A C	onsequence or j	0	/			
PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to death but	not reaulting in	tha underlying cause given in	Part i. 24a. WAS AN A PERFORM	MED? AVAILABLE PRIOR TO		
AN:	DID TOBACCO USE CONTR				IN 🗷			
SICI,	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Important 2 ER/Outpet		THER:				
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW IN.	JURY OCCURED		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, stc. (Specify	- Al home, farm, str	et, lactory, office	281. LOCATION (Street an City or Town, State)	nd Number or Rural Route Number,		
COMPLETED				st lie time, date and place, and du in my opinion, death occured at th		ner as stated. I due to the cause(s) and menner as stated.		
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER	J. /	lan 1		0050	29d. DATE SIONED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO BEN TO CHAR 31. DATE FILED (Month, Day, Year)		VERSID		-188424	mb. 21801		
		d'Audien Randall	UNE					

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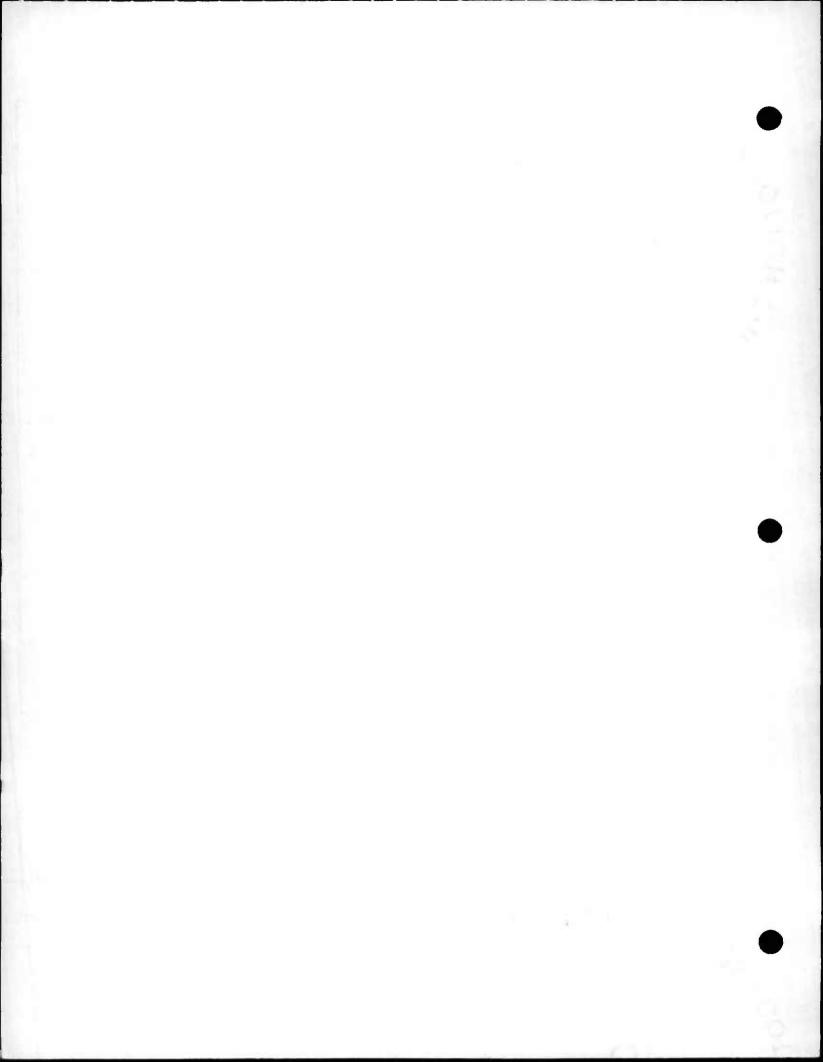
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

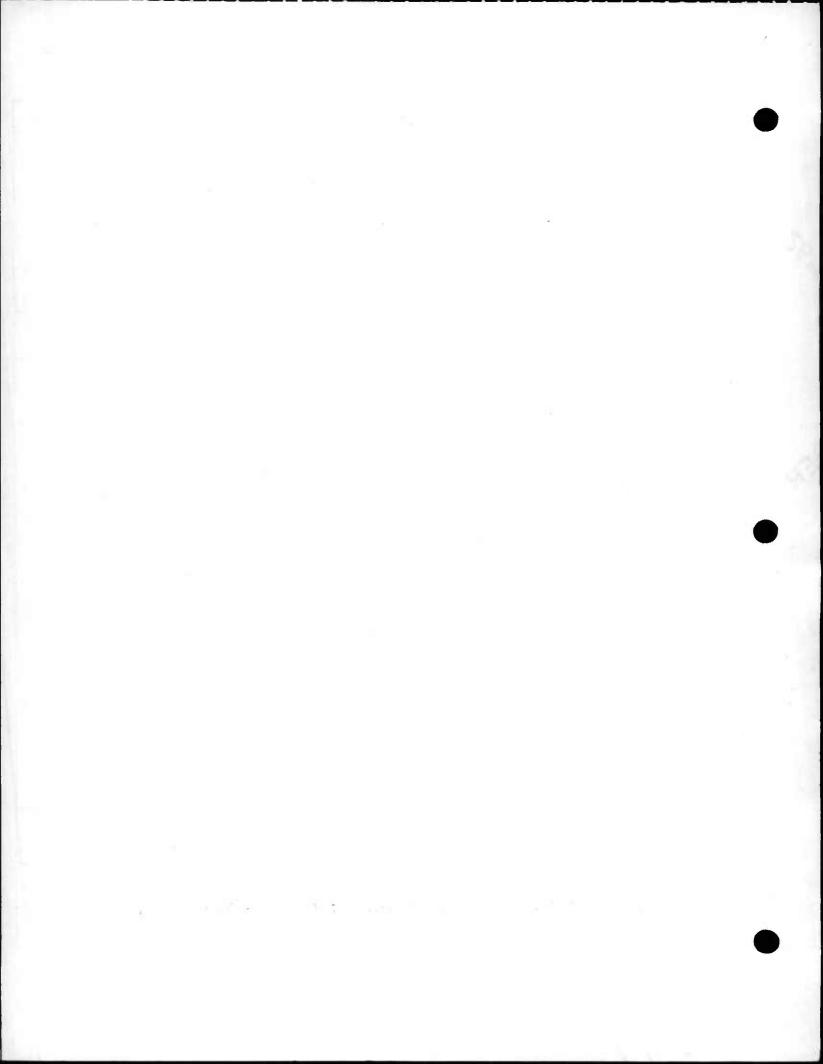
								20	10000	
	1 - FOR STATE REGISTRAR		MARYLAND /	DEPART ERTIFI	MENT OF CATE OF	HEALTH AND DEATH	MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last))					2. DATE OF DEATH MONTH D	AY YE	3. TIME OF DEATH	
	JOSEPH 4. SOCIAL SECURITY NUMBER	ANTHONY		MAZZI			April 11,	1995	11:05 P M	
	111-18-7988	5. SEX 1 X M 2 F	8. AGE (In yrs. In:	YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	Mar 9, 19	0	BIRTHPLACE (State or Foreign Country) NY	
OR	9a. FACILITY NAME (If not institution, give MEMORIAL HOSPIT		96. CITY, TOWN CUMBER	OR LOCATION OF D	PEATH	9c. COUNTY				
RESIDENCE OF DECEDENT 10c. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION										
DIRECTOR	MD All	egany			town or Local berland				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	10e. STREET AND NUMBER				10	of. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
Ä	12106_Old_Cash '	Valley RD				21502		USA		
5	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF	RMED NO	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian, Black, White, etc.	
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			S 2 XNO Speci			Specify: white	
TE	15. DECEDENT'S EDI (Specify only highest grad		(G	live kind of wo	ISUAL OCCUPAT		16b. KIND OF BU	SINESS/INDUST	RY	
Ľ	Elementary/Secondary (0-12)	College (1-4 or 5	-)	. Do NOT use						
COMPLET	17. FATHER'S NAME (First, Middle, Last)	4	R	et. C	ivil En		LOCKW	ood Gre	een	
	Ralph Mazzuco	10					AME (First, Middle, Maiden	Sumame)		
BE	19e. INFORMANT'S NAME (Type/Print)	.a	19	b. MAILING A	ADDRESS (Street	end Number or Rural	Route Number, City or Tow	State Zin Cori	2)	
임	_ Jean Mazzucca		1				Road: Cum			
	20e. METHOD OF DISPOSITION				DISPOSITION (A			CATION — CITY I		
	1 X Burial 2 Cremation 3 Ren 4 Donation 6 Other (Specify)	noval from State		of He		emeterv	04/15 Va	lhalla	. NY	
	21. SIGNATURE OF FUNERAL SERVICE LI	ICENSEE	. /	/	22. NAME A	ND ADDRESS OF F	ICILITY			
	Clamos 7	do	-1//	-	Scar	pelli Fu	neral Home	for Mc	Mahon Funeral	
	23. PARY i. Enter the diseases, or	complications the	caused the de	ath. Do no	t enter the m	erland,	MD 21502	raton, arrest	Home Approximate	
	anock, or neert failure.	List only one cau	se on each line		a contact that have	out or trying, aut	on as cardioc or reapi	ratory arrest,	intarvai Between	
	IMMEDIATE CAUSE (Final disease or condition	ic cardi	liomyopathy					Onset end Death		
ı	resulting in death)	DUE TO	(OR AS A CONSE	QUENCE OF):	:				3 years	
z	Service depends to one to the	Corona	ry arter	v dis	sease				unknown	
일	DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE TO (OR AS A CONSEQUENCE OF):								
Ë	that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CONSEC	DUENCE OF):						
当		d								
. 11	PART II. Other algnificent condition	ns contributing to	death but not r	esuiting in	the underlyin	g ceuse given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL	Diabetes						PERFOR	1100	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ijI							' ' '		OF DEATH?	
ž	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YES	□ NO □	UNCERTAI	N KI		1 1 120 2 NO	
ĕ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one)					
ર્હે હ	1 VES 2 NO	HOSPITAL:	ER/Outpatient 3		OTHER:	ne 5 🗆 Rasidenca	8 Other (Specify)			
E	27. MANNER OF DEATH	28e. DATE OF (Month, Di	INJURY ay, Year)	26b. TIME		JURY AT	28d. DESCRIBE HOW II	JURY OCCURE	D	
à	4 Natural 5 Pending 2 Accident Investigation					YES 2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — At holetc. (Specify)	me, farm, str	eet, factory, offic	•	28f. LOCATION (Street a City or Town, State)	nd Number or Ru	iral Route Number,	
COMPLET	290. CERTIFIER		- 12 12							
₹							to the cause(e) and men			
8			and the contract of the contra	vesigetion,	ni my opinion, o				use(e) and manner ee stated.	
W	29b. SIGNATURE AND TITLE OF CERTIFIE	R /	1			29c. LICENSE NUI		29d. DATE SIG	NED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WI	O COMPI TYTE	/ OF CT : T	1 Am -		D 28	3910	upr	112/94	
								/		
	Dr. H.C. Merrick,	Memoria.	HOSPIT	al Me	dical I	sidg., Cu	umberland,	MD 215	502	
	31. DATE FILA PRY. 1 3 1995	12 000	R'S SIGNATURE	2.14						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
1	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH			3. TIME OF DEATH		
	JACK	KENNEDY	NEDY MURPHY SR.			APRIL 6", 199			5	5 0719 P M		
- 1	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE ((In yrs. last birthday)			7. DATE	ATE OF BIRTH 8 BIS		BIRTHPI Country)	LACE (State or Foreign		
	218-12-5090	YRS.	MONTHS DAY	B HOURS MIN.	May 29, 1923				WV			
~	90. FACILITY NAME (If not institution, give:		- 11 C - A	N OR LOCATION OF				COUNTY OF DEATH				
Ē	217 INDUSTRIAL BLVD W CUMBERLAND, MD. ALLEGAN									ANY		
Ä	10e. STATE 10b. COUNT		ry, TOWN OR LO				IOd. INSIDE CITY					
۵	MD Alle	Cur	nberlan					YES 2 NO				
FUNERAL DIRECTOR	10e. STREET AND NUMBER			101. ZIP CODE			N OF WH	IAT COUNTRY?				
Ä	217 Industrial B	N U.S. ARMED	21502									
	1 Never Merried 2 Merried	2 NO	Icen, Puerto Rican, etc.) Biack,				– Americen Indien, White, etc.					
B	3 Wildowed 4 Divorced	WW II	1 ☐ YES 22 NO Special					iite				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				b. KIND OF BU					
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Retired Brakeman				m '1					
MP	12 17. FATHER'S NAME (First, Middle, Last)	Retire	a Brake	Railroad								
	James R. Murph		16. MOTHER'S NAME (Virgini									
BE	19e. INFORMANT'S NAME (Type/Print)	14, 01.	19b. MAILIN	ADDRESS (Stre	et and Number or Rura				vria)			
2	Dorothy I. Murph	V			l Blvd W					502		
	20s. METHOD OF DISPOSITION	206	PLACE AND DATE	OF DISPOSITION	(Nama of	DA	TF 20c. LO	CATION — CIT	or Town			
	A Donestion 5 Other (Specify) RestLawn Memorial Gardens 04/10 LaVale, MD											
	21. BIGNATURE OF FUNERAL SERVICE LI	21. BIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home										
	Jeanes 7.	& Carpl	11-		erland, N							
	23. PART/I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Approximate											
	/ ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final									Onaet and Death		
	disease or condition resulting in death) a. Coronary Artery Disease Due To (OR AS A CONSEQUENCE OF):								6 years			
N									4 years			
CERTIFICATION												
음	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								+			
H	resulting in death) LAST											
	DART II Other significant conditions contribution to death but and acceptance in the significant conditions of the significant											
CAL	PERFORMED?, A							VERE AUTOPSY FINDINGS				
ED	1 U YES 2 (J NO 0							OMPLETION OF CAUSE OF DEATH?				
Σ									YES 2 NO			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
Sic	EXAMINER? 1 YES 2 40 OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)											
Ŧ	27. MANNER OF DEATH	OF DEATH 286. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							oth			
BY	1 Natural 5 Pending 2 Accident Investigation		A-A 4-	YES 2 NO	2 KNO fell			during ellen				
	3 Usicide 8 Could not be 28. PLACE OF INJURY — At home, Ierm, street, sectory, office 281. LOCATION (Str. building etc. (Specific)							et end Number or Rural Route Number,				
	217 Industrial W Cunt											
AP	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner es stated.											
COMPLETED	One) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(e) end menner ee stated.											
BE (29b. SIGNATURE AND TITLE OF CHITIFIER			29°- LICENSE NU D36766				fonth, Day, Year)				
2	20 NAME AND ADDRESS OF THE					April Sem 199						
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
	31. DATE FILED (Month, Day, Year)	DR. VIK POONAL 955 FREDERICK STREET CUMBERLAND, MD. 21502 31. DATE FILED (Month, Day, Year) 122. REGISTRAR'S SIGNATURE										
ı II	APR 1 3 1995		Carlett									



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia	
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		FOR	TATE OF MADY AND							1 4	
		1 - STATE REGISTRAR	TATE OF MARYLAND / CI	DEPAR ERTIF	ICATE	OF I	DEATH	MENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH				
•	1	Jessie Mae Nisson						04 g	1 9	5	11:15 pm
			SEX 6. AGE (In yrs. le:		IF UNDER 1		HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		Country)	ACE (State or Foreign
P	- 1		□ M 2 🔀 F 84	YRS.			MIN.	April 7, 19	911	N. C	Carolina
should	00	9a. FACILITY NAME (If not institution, give street of					LOCATION OF DI	ATN		Y OF OEAT	
2, 3	CTOR	Pleasant Living Con	nvalescent Cer	ter	Eag	jewat	er		Anne .	Arund	lel
physician. burial-transit permit. Pages 1,	<u> </u>	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OF	R LOCATIO	ON			104	d. INSIDE CITY
2	DIRE	MD 2	Anne Arundel	C	hurch	iton				11	LIMITS?
permi	AL	10s. STREET AND NUMBER				_	ZIP CODE		10g. CITIZE		T COUNTRY?
insit	FUNERAL	5604 Carroll St	treet				2	0733	US	A	
Siciar lal-tra	5		WAS DECEDENT EVER IN U.S. AR	MED	13. W	AS DECE	NDENT OF NISPAN	IIC ORIGIN? (Specify Ye	s or No- 1	4. RACE -	American Indian,
P P	ВУ Б		FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES			If yes, specify Cuban, Maxico		can, Puarto Rican, atc.)		Black, White, atc. Specify:	
attending physician se as the burial-trai											white
=	ETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	eleted) (G	ive kind of I	Work done du	CUPATION uring most	of working	16b. KIND OF BU	SINESS/INDUS	STRY	
# 2	=	Elementary/Secondary (0-12) Co	llege (1-4 or 5 +)	Bakery operator				food service			
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	Бо	iker	y ob	ега		food ME (First, Middle, Maiden		ıce	
by the	C H	Luraco	,	ork			Alice	Henrie	,	Mull	ie
retained 5 should notified	00	19a. INFORMANT'S NAME (Type/Print)			ADORESS	(Street and		rel Route Number, City or Town, State, Zip Code)			15
	2	Alma W. Nisson	1	same as # 10 above							
may be or. page		20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City of Town, State									
T recti e		1 Burlet 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) Macedonia Meth. Cemet. 4/26/95 Harmony, NC									
. Page ral dire		21. SIGNATURE OF FUNERAL SERVICE LICENSE					AOORESS OF FA				
B		Rausch Funeral Home, P.A., Owings, MD									s, MD
के के ब		23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory strest, abook, or heart failure. List only, one cause on each line.									
filled in on, or n		IMMEDIATE CAUSE (Final	only one cause on each line	1							Interval Between Onset and Death
		disesse or condition							Munass		
			DUE TO JOH AS A CONSE	A CONSEQUENCE OF):							1 Ochars
executed and com o burial.	Z	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									
e be execut sician and c prior to buri traumatic	CATIO										
cate ohysic e pric	<u> 2</u>										
n certificate nding physi Hygiene pr or other t	RTIFI	that initiated events Due TO (OR AS A CONSEQUENCE OF): resulting in dasth) LAST									
두 등 등	CE	d.									
the d	4	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
that the by the and th	EDIC/	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE									
requires that been signed b of Health ar	MEC										DEATH?
law requast been bept. of 1		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I									
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATN (Check only one)									
SICIAN: The certificate h the State	Sic	EXAMINER? 1 YES 2 NO									
this cer with th	РНҮ	27. MANNER OF GEATN	28s. DATE OF INJURY (Month, Day, Year)	26b. TIME OF NORTH WORK? M 26c. INJURY AT WORK? 1 YES 2 NO At home, farm, atreet, factory, office			26d. DESCRIBE HOW INJURY OCCURED				
NG PHYS fter this casth with marked	BY	1 Natural 5 Pending 2 Accident Investigation									
P A P		3 Suicide 8 Could not be	26a. PLACE OF INJURY — At ho- building, atc. (Specify)				281. LOCATION (Street and Number or Rural Route Number, City or Rown, State)				
OR ATTEN DIRECTOR: hours after item 28 Is	ETE	4 Homicide detarmined					Only of Purit, Gleen				
	OMPLE	29a. CERTIFIER 1 CERTIFYING PHYSICIAN:	To the best of my knowledge, de	th occurre	d at the tim	ne, data ar	nd place, and due	to the cause(s) and man	ner as stated.		
OSPITAL INERAL thin 72 t	NO.		the basis of examination and/or i								f manner as atated.

OF DEATH (ITEM 27) (Type, Print)

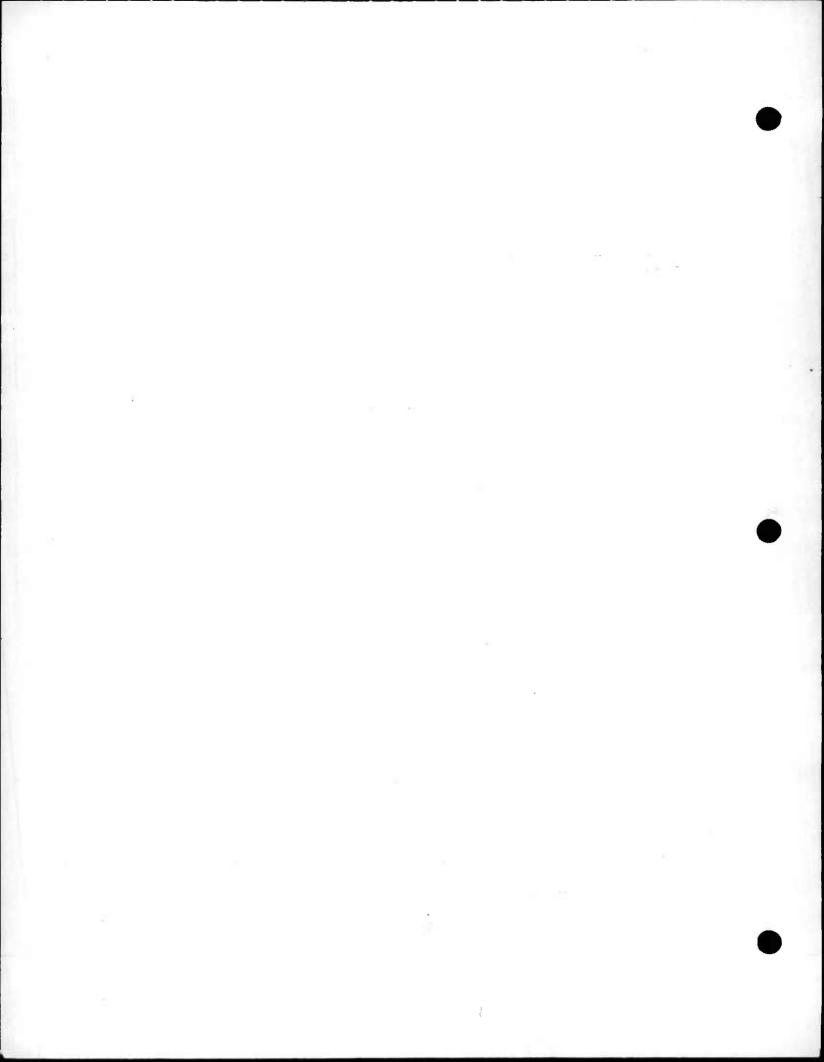
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29c. LICENSE NUMBER

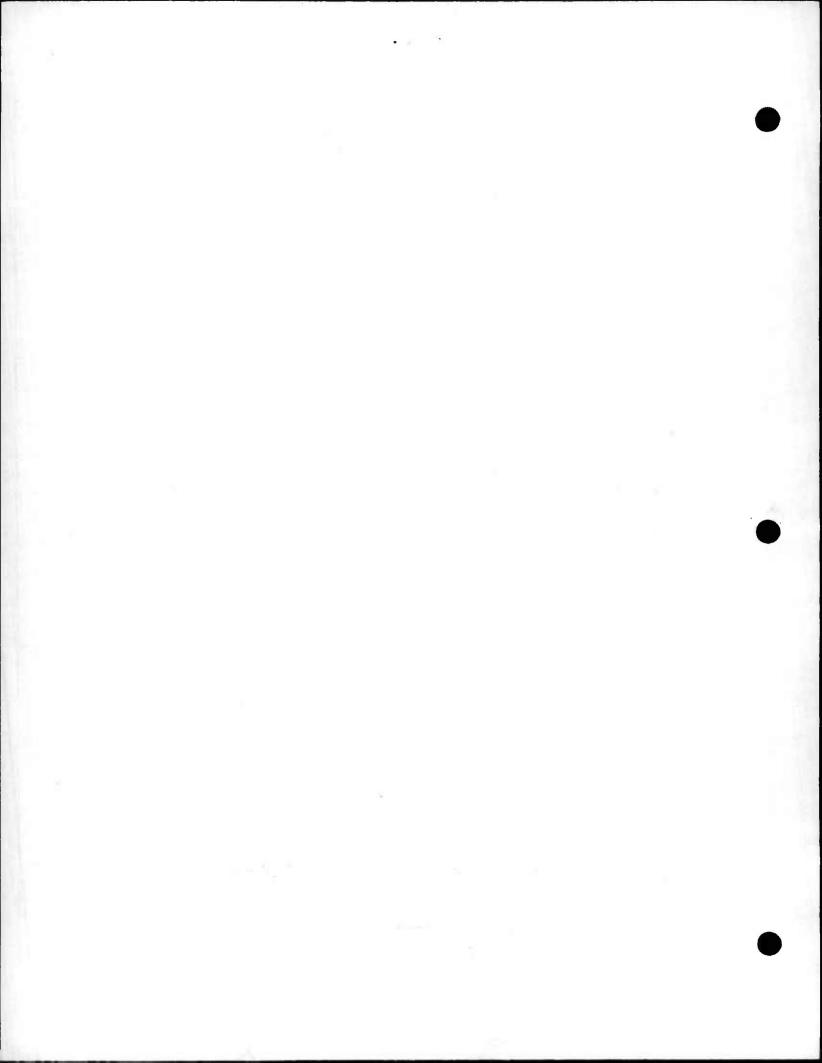
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TO BE

Lothian



			1 - FOR STATE REGISTRAR	STATE OF MARY		ARTMENT OF I		MENTAL HYGIEN		
	59		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	1		HILDA CHANNEL	L NEAL					3, 199	9:20 A. M
	10				E (In yrs. lest birthda)	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9		213 14 2037	1 D M 2 5 F	7.3 YRS.			1/10/19:		Maryland
	Z, 3 should	DIRECTOR	Se. FACILITY NAME (If not institution, give streets St.e. 11a Maris Ho				OR LOCATION OF O	EATH		y of OEATH ltimore
	. Se	EC	10a. STATE 10b. COUNTY		10c. C	ITY, TOWN OR LOCA		10d. INSIDE CITY		
ć	permit. rages	AL DIR	Maryland Har	ford	St	reet	f. ZIP CODE		10a CITIZE	1 YES 2 NO
		E	3518 Prospect R	oad			2115	54		ted States
020 physician.	Dunai-transit	FUN	11. MARITAL STATUS	2. WAS DECEDENT EVER	R IN U.S. ARMED	13. WAS DEC	CENDENT OF HISPA	NIC ORIGIN? (Specify Yes		4. RACE — American Indian.
000 g	ane por	ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YE			NO Specific	an, Puerto Rican, atc.) /y:		Black, White, stc. Specify:
S 5	Se Se		15. DECEDENT'S EDUCA	FION	160 DECEDENT	TO LIGHT A CONTINUE		T		White
12 or at	25	ETED	(Specify only highest grade co	mpleted)	(Give kind o	'S USUAL OCCUPATION of work done during mo	ON ost of working	16b. KIND OF BU	SINESS/INDU	STRY
	Date of the last	PL	Unknown	College (1-4 or 5+)	Hom	emaker		Own	home	
AND atthe hospital	once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		11011	CIIICACI	18. MOTHER'S NA	AME (First, Middle, Maiden		
Y	क ह	ш	Hillen Hollow	ay			Margie	e McClear	У	
MARYLAND retained by the hospit	notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street a	and Number or Rural	Route Number, City or Tow	n, State, Zip C	ode)
	, [F	Donna C. Snod	grass	3518	Prospe	ct Road	d Stree	et, Mi	D 21154
may be	must b		20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove		Ob. PLACE AND DAT	E OF DISPOSITION (No	ame of	DATE 20c. LO	CATION — CI	ty or Town, Stata
MO age 6	E 1		4 Donation 5 Other (Specify)	lČ	entre	Cemeter		4/26 Ne	w Par	k, PA
ALTIMORE, death. Page 6 may be	examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN	ger D	11	22. NAME A	ND ADDRESS OF FA	CILITY		
BALTIMORE, after death. Page 6 may be	niled in by the on, or removal. he medical e		Cheffin P	- Love	ledy					c. Delta, PA
7.24 hours af		ii ii	23. PART I. Epide the dispess, or conshock, or heart failure. Lin IMMEDIATE CAUSE (Finel disease or condition	mplications that cause on	each line.	not enter the mo	ode of dying, suc	th as cardiec or respi	ratory arres	Approximate interval Between Onset and Death
executed within			resulting in death) s.	DUE TO (OR AS	S A CONSEQUENCE	OF):				a ryears
39 N	5.6	NO NO	Sequentially liet conditions, b.	DUE TO (OR AS	A CONSEQUENCE	OF):				
P.O. BOX th certificate be a		CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							į
O. B. certificate		H	that initiated evente resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):			-	
S, P.O	tal Hy	Ä	d.							
S	용호	4	PART II. Other significent conditions	contributing to death	but not resulting	in the underlying	g ceuse given in	Pert i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
RECOR	pt. of Health and I	MEDICA						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
RE Leading	shov	Σ	DID TOBACCO USE CONTRI	RITE TO CAUSE	OF DEATH V	ES D NO D	UNCERTAI	NI SEL		t 🗌 YES 2 🗍 NO
TAL The law	9 8	AN	25. WAS CASE REFERRED TO MEDICAL	BOIL TO CAUSE		ATH (Check only one)	UNCERIAI	N ASI	_	
⊢ ⊢ ≗	or Item	PHYSICIAN:		IOSPITAL:	utpatient 3 DOA	OTHER:	e 5 🗆 Realdence	6X☐ Other (Specify)	Hospi	CA
PHYSICIAN:	. = .	Ť	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)		ME OF 28c. INJ		28d. DESCRIBE HOW II		
2 5 5	death with	BY	t Natural 5 Pending Z Accident Investigation	(moran, buy, rous)			YES 2 NO			
OR ATTENDING F	after de	ETED E	3 Suicide 8 Could not be determined	28e. PLACE OF INJUI building, atc. (Sc	RY — At home, ferm pecify)	, street, factory, offic	•	28f. LOCATION (Street a City or Town, State)	and Number or	Rurel Route Number,
	hours	PE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the beat of my kno	owledge, death occu	rred at the time, date	and place, and due	to the cause(a) and man	ner ee stated.	
SPITA	within 72 I	COMPL								cause(a) and manner as stated.
THE HOSPITAL	HTA WIE		29b. SIGNATURE AND TITLE OF CERTIFIER	- 04			29c. LICENSE NUM	WBER	29d. DATE S	SIGNED (Month, Day, Year)
5 5	be filed within 7.	TO BE	Kondell Rf	aukal	uno		D 056	143	D 4	123/95
		F	30. NAME AND ADDRESS OF PERSON WHO						//	-
			DR. KENDALL FAULK 31. DATE FILED (Month, Day, Year)	NEK 2300	DULANEY '	VALLEY RE)., TOWSO	ON, MD 212	204	
			APR 26 1995	JULY THE STORE	orkarlat					



215	atten	
=	6	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten	The state of the s
A	he	
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use as the burial-transit permit. Pages 1, 2, 3 should ding physician. Por detached TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 75 hours after death. Page 6 may be retained by the THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be on the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumattic event, the medical examiner must be notified at or

APR

1 Natural 2 Accident 3 Suicide

COMPLETED

BE 2

							95	13592	
	1 - FOR STATE REGISTRAR	ATE OF MARYL		RTMENT OF I		MENTAL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Adams J		Nelso	on		April 3, 1	1995 YEA	6:33 Pm	
	4. SOCIAL SECURITY NUMBER 5. SE		'in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. B	IRTHRUACE (State or Foreign	
	253-24-7135 1 th	M 2 🗍 F	76 YRS.	MONTHS DAYS	HOURS MIN.	April 30	1918	Florida	
	Sa. FACILITY NAME (If not institution, give street an	id number)		9b. CITY, TOWN	OR LOCATION OF DE		Oc. COUNTY C		
띩	Washi mgton Advent	ist Hosp	ital	Tako	ma Park	c, Md	Mont	tgomery	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY						1.011		
E I		gomery		TY, TOWN OR LOCA	TION			10d. INSIDE CITY V LIMITS?	
	10e. STREET AND NUMBER	gomery	I A	delphi				1 N YES 2 NO	
¥	1801 Metzerott	Dd		10	I. ZIP CODE			OF WHAT COUNTRY?	
FUNERAL			III ADMED	10 000 000	20783			States	
	1 Never Married 2 Merried F	ORCES? 1 X YES	2 NO	If yes, sp	ecify, Cuban, Maxica	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No 14. F	RACE — American Indian, Black, White, atc.	
BY	3 Widowed 4 Divorced	YES, GIVE WAR OR DA	AIES	1 _ YES	2 NO Specify	y:	F	lack	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	1	18a. DECEDENT'S	USUAL OCCUPATION	ON	18b. KIND OF BUS			
<u>-</u>	Elementary/Secondary (0-12) Colle	ege (1-4 or 5+)	life. Do NOT u	work done during mo se retired.)	ist of working				
M M	12		Secre	et Serv	ice	Gov	ernmer	nt	
8	17. FATHER'S NAME (First, Middle, Linst)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)		
BE	John Henry Nelso	on				ry Harris			
0	19a. INFORMANT'S NAME (Type/Print)	-				Route Number, City or Town			
-	Jamil Rasheed		3921	Clark :	St. Ca	pital He	ights,	Md. 20743	
	2¶a. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Removal fro	om State com	PLACE AND DATE	OF DISPOSITION (Na			CATION - City o		
	4 Donatton 5 Other (Specify)		dery, cranetory or c	-		11-95 Cheltenham, Md. FACILITY Capitol Mortuary			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1	000	22. NAME AI	ID ADDRESS OF FA				
	> HUMM XUM	Mon-	accey	1425	Maryla	nd Ave.,			
	23. PART I. Enter the diseases, or compil	icetions that coused	tha death. 66	not anter the mo	de of dying, auci	h as cardiec or respi	ratory arrest,	Approximata	
	shock, or heart failure. List or IMMEDIATE CAUSE (Final	nly one cause on a	nch line.					Interval Batween Onset and Death	
1	disease or condition	an	120 M	Marsh	el un	mis		//	
i	reaulting in death) a	DUE TO OR AS A	CONSEQUENCE O	h:	0		1	1602	
z		USB	241189	forde.	Caple	cont	2/189	ce The	
음	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O						
3	CAUSE (Disease or Injury								
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
H H	d								
	PART II. Other significant conditions cont	tributing to death b	ut not reaulting	in the underlying	ceuse given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
2	Durcity	muce			1	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
						1 TYES 2	NO NO	OF DEATH?	
≥	DID TOBACCO USE CONTRIBUT	TE TO CAUSE O	E DEATH Y	S I NO I	UNCERTAIN			1 NES 2 NO	
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	41-11	26. PLACE OF DEA	TH (Check only one)	DITCERIAIN	·			
Sic	EXAMINER? 1 YES 24 NO 1 1 1	SPITAL: X Inpetient 2 ER/Outpo		OTHER:	6 Bestdans	6 [] Other (0: 127)			
Ĭ		28a. DATE OF INJURY	28b. TIN	E OF 28c. INJ	URY AT		Other (Specify) OESCRIBE HOW INJURY OCCURED		
ВУР	1 Natural 5 Pending Investigation	(Month, Day, Year)	IN.	JURY WO	RK7 ES 2 NO		Joodille		
00	2 Accident trivestigation								

28a. PLACE OF INJURY — At home, term, street, factory, offica building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

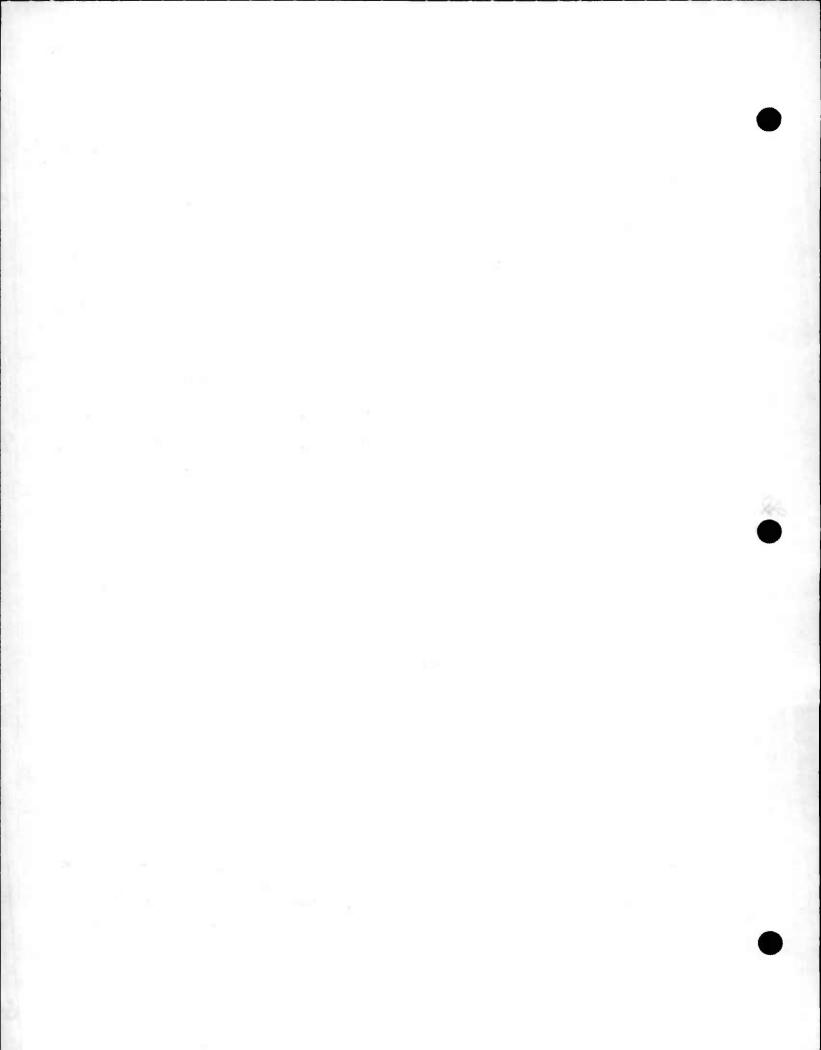
29a. CERTIFIER (Check only one)

occured at the time, data and placa, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

1995

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LENKIN Myron 31. DATE FILEO (Month, Day, Year)

Julia Davidson Revolate

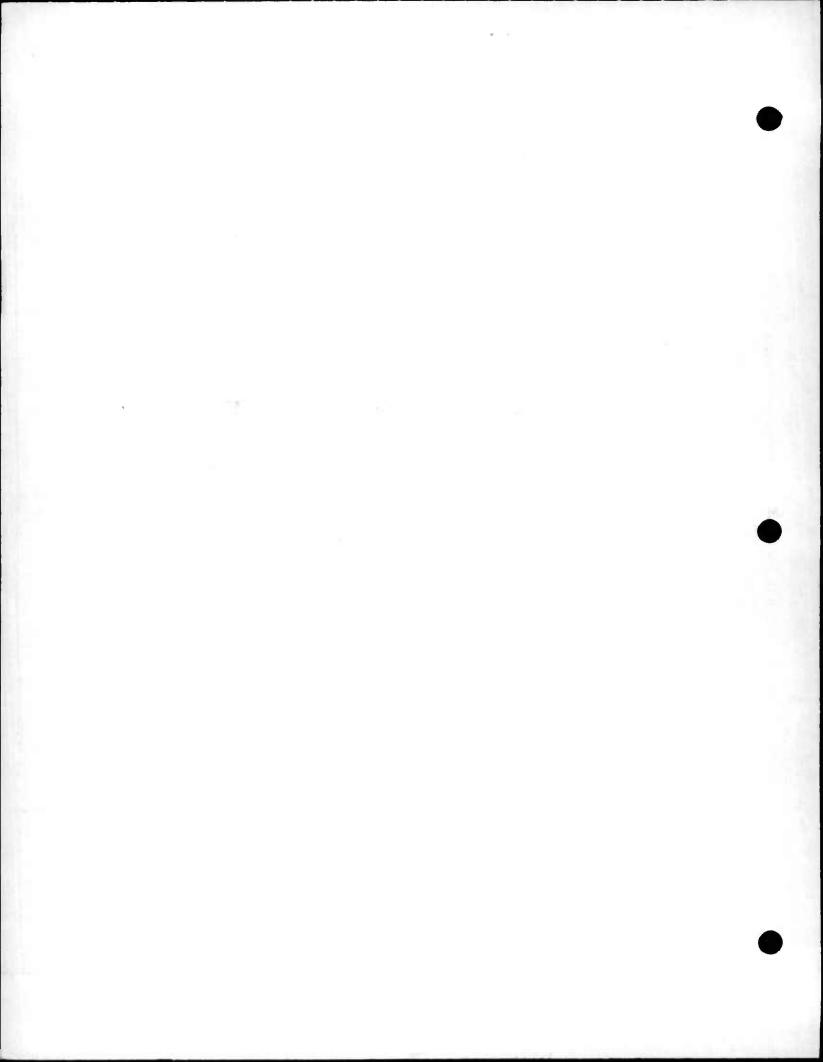


DIVISION OF VITAL RECORDS. P.O. BOX 68760

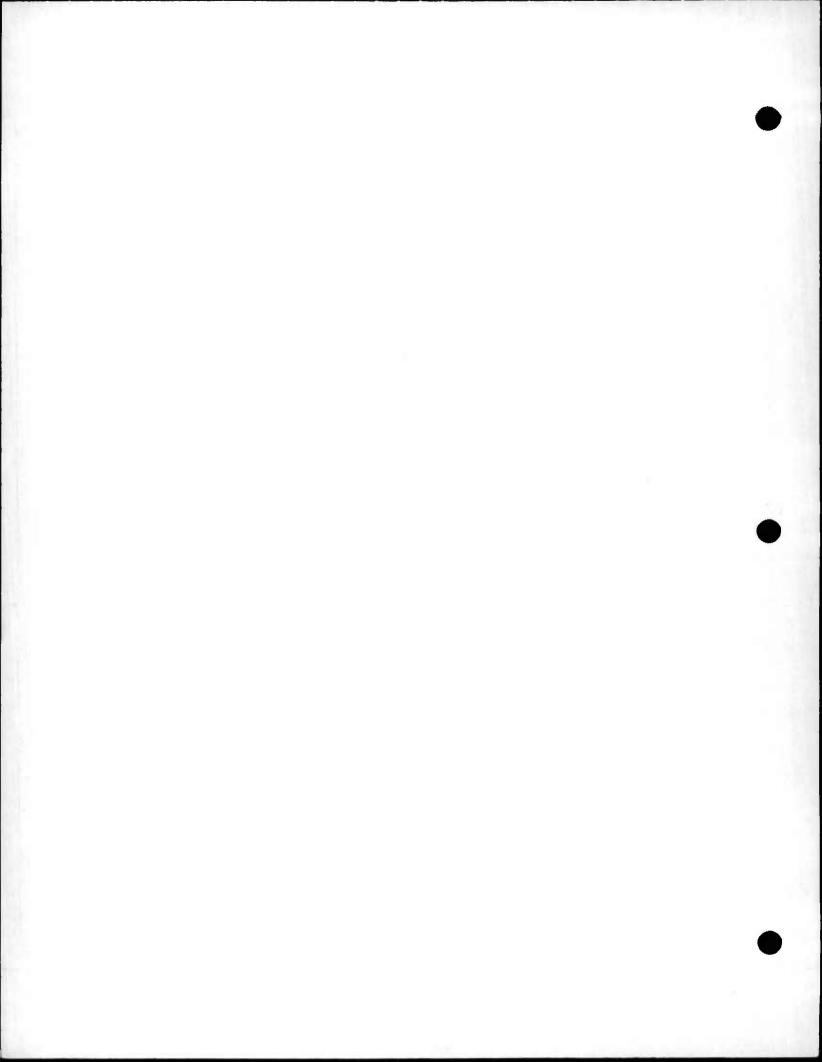
FOR 1 - STATE REGISTRAR

		REGISTRAN		CE	- NIIF	ICALE	UF	DEAL	п	REG. N	D		
		1. DECEDENT'S NAME (First, Middle, Last) William	Roy		Newmo	an				2. DATE OF DEATH MONTH, April 6,	DAY 1995	VEAD	TIME OF DEATH
_		4. SOCIAL SECURITY NUMBER 579-40-0082	5. SEX 6. A	GE (In yrs. las	t birthday)	IF UNDER 1	DAYS	IF UNDER HOURS	24 HRS. MIN,	7. DATE OF BIRTH	1929		ACE (State or Foreign
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 10c. COUNTY OF DE. 10c. COUN											
physician. burial-transit permit. Pages 1,	DIRECTOR	Mary Tand Prince	George's		10c. CITY, TOWN OR LOCATION BOWIE								0d. INSIDE CITY LIMITS?
ısıt permit	FUNERAL	100. STREET AND NUMBER 4501 Lottsford Visi	ta Road				101	f. ZIP CODE	2072	20	10g. CIT		YES 2 NO AT COUNTRY?
2 2 2	B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 X N	MED	I N	yes, sp	CENDENT OF	F NISPANI n, Maxican Specify:	C ORIGIN? (Specify Y., Puerto Rican, etc.)	a or No—	1.0000000000000000000000000000000000000	- American Indian, White, atc. Black
thend the as	8	15. DECEDENT'S EDUC	ATION	16a, DE	CEOENT'S	USUAL OC	CUPATIO	ON	_	16b. KINO OF BI	ISINESS/IN	OUSTRY	
Spital or ed for u	COMPLETED	(Specify only highest grade	College (1-4 or 5+)	(Gi	ve kind of w Do NOT us Landso	vork done du e retired.)	uring mo	ost of working	9	William (tired)
ज ह	BE CON	17. FATNER'S NAME (First, Middle, Last) Leo Thompso					18. MOTN	ER'S NAM	NE (First, Middle, Meide Mary Newmar				
y be retained to age 5 should be notified	TO E	190. INFORMANT'S NAME (Type/Print) Mrs. Helen Newman (Wit	e)	196	MAILING 501 LC	ADDRESS Ottsfo	rd V	ista F	or Rurel Ro Road	Bowie, Mary	n, Stete, Zi	20720	
e 6 may rector, pa		20a. METHOD OF DISPOSITION 1 State 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify). 20b. PLACE AND DATE OF DISPOSITION (Name of 4/10/95 Clinton, Maryland											
0 - 0		· Jonet C	· hade	Son	M.	4	339	Hunt F	Place,	Home, Inc. N.E. Wash		-	20019
within 24 hours optetely filled in cremation, or n		23. PARTY. Enter the diseases, or cannot shock, or heart feilure. If immediate cause (Final disease or condition resulting in death)	omplications that cau list only one ceuse of the case of DUE TO (OR A	n eech iine.								rrest,	Approximate interval Between Onset end Daath
8 5 3 6	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A						_				
th certificate be execute ending physician and co I Hygiene prior to buria or other traumatic	RTIFICA	csuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR A	AS A CONSEO	UENCE OF):							
	1111	Tooding in death) Exs											
that the ded by the h and Me	DICAL	PART ii. Other significant condition	contributing to deet	h but not re	sulting i	n the und	leriying	g ceuse gi	iven in P	Part I. 24a. WAS AI PERFO	RMED?	AM CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATN?
of she	≝	DID TOBACCO USE CONTR	BUTE TO CAUSE			_		UNCE	ERTAIN	<u> </u>		- 1	☐ YES 2 ☐ NO
Sician: The certificate h the State (d. or Item	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINED? 1 7 TES 2 1 NO	HOSPITAL:			OTHER:							
F with start	ву Рну	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJUI (Month, Day, Yea	RY	28b. TIME	OF 2	8c. INJ			Other (Specify) 28d. DE\$CRIBE NOW	INJURY OC	CURED	
DR ATTENDING I DIRECTOR: After hours after death tem 28 is mar	8	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJU building, etc. (S	JRY — Al hon Specify)	ne, farm, e	treet, factor	y, office			281. LOCATION (Street City or Town, State	and Numbe	r or Rurel Rout	e Number,
RAL DIRI	COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINE	CIAN: To the best of my kr										
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT. II	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIES	2 1 000	MN	1	i, iii niy opi	1	-	VSE NUME				onth, Day, Year)
PPAM	101	1611 000	- 1/ - 1	DEATH (ITEM	27) (Type)	Print) /.		11	1	5 11	Topse	17,1	995
10)	31. DATE FILED (MOVIN), Day, Viliati	-	IGNATURE R	9/0	ey/h	ero	ict.	Co	gn. M	20	740	
		WLK TO 1333	0	STEELER W.	of the state of								

		1 - FOR STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR	TMENT OF	F H	EALTH AND	MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, M		ELANEY	L.		VER,			D D D D D D D D D D	MO	TE OF DEATH	AY	YEAR 995	3. TIME OF DEATH 6:09 P. M
8 0/8		4. SOCIAL SECURITY NUMBER 421-24-8800	1	5. SEX 1 [X] M 2 □ F	6. AGE ((In yrs. lasi		IF UNDER 1 YEA	ivs.	IF UNDER 24 HRS. HOURS MIN.	7. DAT (Mc Ja	re of Birth onth, Day, Year) n 21, 1			PLACE (State or Foreign
i, 2, 3 should	TOR	90. FACILITY NAME (If not instite WASHINGTON A	ADVENT		PITA	L				PARK	EATH			TY OF DE	
permit. Pages 1,	DIRECTOR		Ob. COUNTY	E GEORG	ES			WASH							10d. INSIDE CITY LIMITS? 14 YES 2 NO
-55	FUNERAL			ON ROAD 20744					UNITE				HAT COUNTRY? STATES		
215-0020 attending physician. Ise as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Ma 3 Widowed 4 Divorce	erried	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$					ENDENT OF HISPA Helfy Cuban, Maxic 2 NO Speci	an, Puart	GIN? (Specify Yes to Rican, etc.)	or No—	14. RACE Black, Specify	— American Indian, White, atc.	
21 21 21	15. DECED (Specify only hi Elementary/Secondary (9-12	ENT'S EDUCAT ighest grade coi	College (1-4 or 5 +) (Give kind of work done life. Do NOT use retired.)			rork done during e retired.)	done during most of working red.)								
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	E COMPLETED	17. FATHER'S NAME (First, Middle DELANEY OLIV		4 R.		300.	IAL W	WORKER	T	18. MOTHER'S NA				TY G	GOVERNMENT
61 44	TO B	19a. INFORMANT'S NAME (Types DELANEY A. C	Print) Char	rles 01:	iver	19b.		ADDRESS (Street	or,	Number or Rural	Route Nu	Imber, City or Tow	TTE ZIA	TON,	20748 20744
TORE e 6 may ector, pa		20a. METHOD OF DISPOSITION 1	3 🗆 Remove		20b.	PLACE AND USE OF THE PLACE AND	ND DATEON		AL	CEMETER	RY 4	ATE 20c, LO	CATION — C	aty or Tow	
		· allex	S to	uh.		M859		ALEX 5538	XAN 8 N	NDER S. MARLBORO	POP	KE, FOR	RESTVI	LLE.	MD 20747
760 ed within 24 hours ompletely filled in bil, cremation, or re-		23. PART I. Enter the diseshock, or hear IMMEDIATE CAUSE (Final disease or condition resulting in death)	it lanure. Lis	ARTER	IOSCI	LERO		CARDIO		SCULAR I			ratory arre	eat,	Approximate Interval Between Onset and Death
P.O. BOX th certificate be a ending physician I Hygiene prior to or other traum	CERTIFICATION	Sequantially list condition if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ta				UENCE OF)								
RECORDS, P. w requires that the death or been signed by the attend out of Health and Mertal H shows any injury, or	PHYSICIAN: MEDICAL (PART II. Other algorificant END STAGE DEPENDENT	E RENAI	L DISEAS ETES MEI	SE LLITU	US						24s. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
VITAL I	CIAN	DID TOBACCO USE 25. WAS CASE REFERRED TO M EXAMINER?	IEDICAL	OSPITAL:			OF DEATH	H (Check only or		UNCERTAI	ΝЦ				
F VI.	HYSI	1 YES 2 NO	1	Inpatient 2 D					_	5 Rasidence	_				
ON OD DING PHYS After this death with	BY PI	1 📉 Netural 5 🗌 Pen	nding atigation	(Month, De	ny, Year)		INJU	JRY	WOR	K?	286. DI	EŞCRIBE HOW IP	JURY OCCI	JRED	
ISIC TTENDI TTENDI TTOR: A after da		4 Homicide deta	uld not be armined	building,	atc. (Speci	rfy)		reet, factory, o			Cit	CATION (Street a y or Town, State)			ute Number,
DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC De filed within 72 hours IMPORTANT: If Item	COMPLETE	2 MEDICAL	L EXAMINER: C	N: To the best of ax	my knowle	edge, deet and/or in	th occurred	i at the time, d	late at	and place, and due	to the c	ause(a) and man	ner as atate	d. cause(s)	end manner se stated.
TO THE P TO THE P De filed v	98	29b. SIGNATURE AND TITLE OF 30. NAME AND ADDRESS OF PE	and	wore.	no				1	29c. LICENSE NUI DO185					Month, Day, Year) 7, 1995
(8)		Dr. Paul A. D	evore,						JAC), HYATI	SVI	LLE, MD	. 207	81	
		31. DATE FILED (Month, Day, Year APR 12 199	5 Ju	32. REGISTRAI	R'S SIGNA	ATURE									



1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL	HYGIENE REG. NO.				
		tes			монтн	1		3. TIME OF DEATH		
244-68-4058 1 M 2 MF 53 YRS. MONTHS DAYS HOURS MIN. (MONTH, Day, 164)								HPLACE (State or Foreigh My) Wilson Count n Carolina		
HOLY (TOL	s Hospil	el)	1 11	A	h	3 90.0		Gonery		
Maryland Prince				CATION			10d. INSIOE LIMITS' 1 YES:			
1405 Southern Avenue				20745		Uni of	ted Sta America			
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	S 2 X NO	If yes,	specify Cuban, Mexico	en, Puerto Ri	(Specify Yee or No- cen, etc.)	Spec	E — American Indian, ik, White, etc. ify: ack		
		(Give kind of tife. Do NOT u	work done during se retired.)			National Institute of He				
17. FATHER'S NAME (First, Middle, Last) Willie Lee Oates										
William Oates			1910 Clairemont Circle, Wi							
1 💢 Burlel 2 🗆 Cremetion 3 🗆 Rem 4 🗆 Donation 6 🗆 Other (Specify)	oval from State	Winstead Ce	metery			Nash Cou	nty, N	own, Slate orth Carolina		
Downard 6	Coupe #M0069	90 √ 1	Edwa	rds Funeral	Home	Wilson, No	orth Ca	rolina 27893		
23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cause List only one cause on DUE TO (OR AS	oresh	inalo	- 1	50		arreat,	Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PART II. Other algorificant condition		contributing to death but not resulting in the underlying cause given in Pa					E-01/ E-03/	WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
DID TOBACCO USE CONTI	RIBUTE TO CAUSE (N DI			1 PES 2 NO		
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH		tpetient 3 🗆 DOA	OTHER: 4 Nursing H	ome 5 🗆 Residence						
1 Maturel 5 Pending Proceedings Proceeding	(Month, Day, Year)	194.	M 1	WORK? YES 2 NO	10.0 X (10.0 X	and the value of the color		To an il order		
4 Homicide determined	building, etc. (Sp.	ecify)	TELL CASTOCOCI		City or	Town, State)	4-140.30	NOUTH PROPERTY.		
(Check only one) 2 MEDICAL EXAMINE	R: On the beale of examinati			, death occured at the	time, date e	nd place, end due t	o the cause(
30, NAME AND AGGRESS OF PERSON WHI	COMPLETED CAUSE OF O	EATH (ITEM 27) (Torne	Print)	D436	26	>	4 3	95		
ANCES QUYTU 31. DATE FILED (MONTH, De), Year)	M, KAISE	R FORM	ANENTE	6/04/	Old 1	Brande	, Ave,	ropele Hill		
APR 18 1985 &	elik Davidsor Ra	rdati						DHMH-18 Rev 1/89		
	1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 244-68-4058 1. ACCILITY NAME (If not Institution, give selection) 1. ACCILITY NAME (If not	1. DECEDENT'S NAME (First, Middin, Last) 1. DECEDENT'S NAME (First, Middin, Last) 1. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 3. SEX 4. SOCIAL SECURITY NUMBER 2. SEX 3. AG 2. SEX 4. AG 4. SOCIAL SECURITY NUMBER 2. SEX 5. SEX 5. AG 4. MAY 2 F 1. May 2 F 1. May 2 F 1. May 2 F 1. May 2 F 1. May 2 F 1. May 2 F 1. May 2 F 1. May 3 May 2 F 1. May 2	1. DECEDERTY NAME (First, Mickin, Last) 4. SOCIAL SECURITY NUMBER 244-68-4058 5. SEX 1. M 2 D F	1. DECEDENTS NAME (FIRST, MIGGIN, Last) WILLIAM SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrx. last birthday) 90. CITY, TOWN OR LO 10. COLNTY 10. STATE 10. COLNTY 10. COLNTY 10. STATE 10. COLNTY 10. COLNTY 10. STATE 10. COLNTY 10. STATE 10. COLNTY 10. STATE 10. COLNTY 10. STATE 10. COLNTY 10. COLNTY 10. COLNTY 10. COLNTY 10. STATE 10. COLNTY	1. OBJECTION OF DECATH 1. OBJECTIVE OF DEATH 1. OBJECTIVE OF DEATH 2. SPEX 2. S. AGE (in yrs. lead betwood) 2. S. SPEX 3. SAGE (in yrs. lead betwood) 3. SPEX 4. SOCIAL SECURITY NUMBER 3. SPEX 4. SOCIAL SECURITY NUMBER 5. SPEX 5. SAGE (in yrs. lead betwood) 4. SOCIAL SECURITY NUMBER 5. SPEX 5. SAGE (in yrs. lead betwood) 5. SPEX 5. SAGE (in yrs. lead betwood) 5. SPEX 5. SAGE (in yrs. lead betwood) 5. SPEX 5. SAGE (in yrs. lead betwood) 5. SATE BETWOOD OF DECEMENT 6. SECTIVE TOWN OR LOCATION 6. STATEST AND INJURIES 6. SCRIPT TOWN OR LOCATION 7. STREET AND NUMBER 7. STREET AND NUMBER 7. STREET AND NUMBER 7. STREET AND NUMBER 7. STREET AND NUMBER 7. STREET AND NUMBER 7. STREET AND SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTION TOWN OR SECTIVE OF HISPART 7. STREET AND SECTION TOWN OR SECTION	1. DECEMPTS NAME (PM, MOSO, LAST) L. DECEMPTS NAME (PM, MOSO, LAST) L. SOCIAL SECURITY NUMBER L. SO	1. DECEDENT SUMMER (PSY, MODE, LEDNING) 1. DECEDENT SUMMER (PSY, MODE, LEDNIN	1. SECURITY NUMBER 1. SEC. 1. SECURITY NUMBER 1. SEC.		



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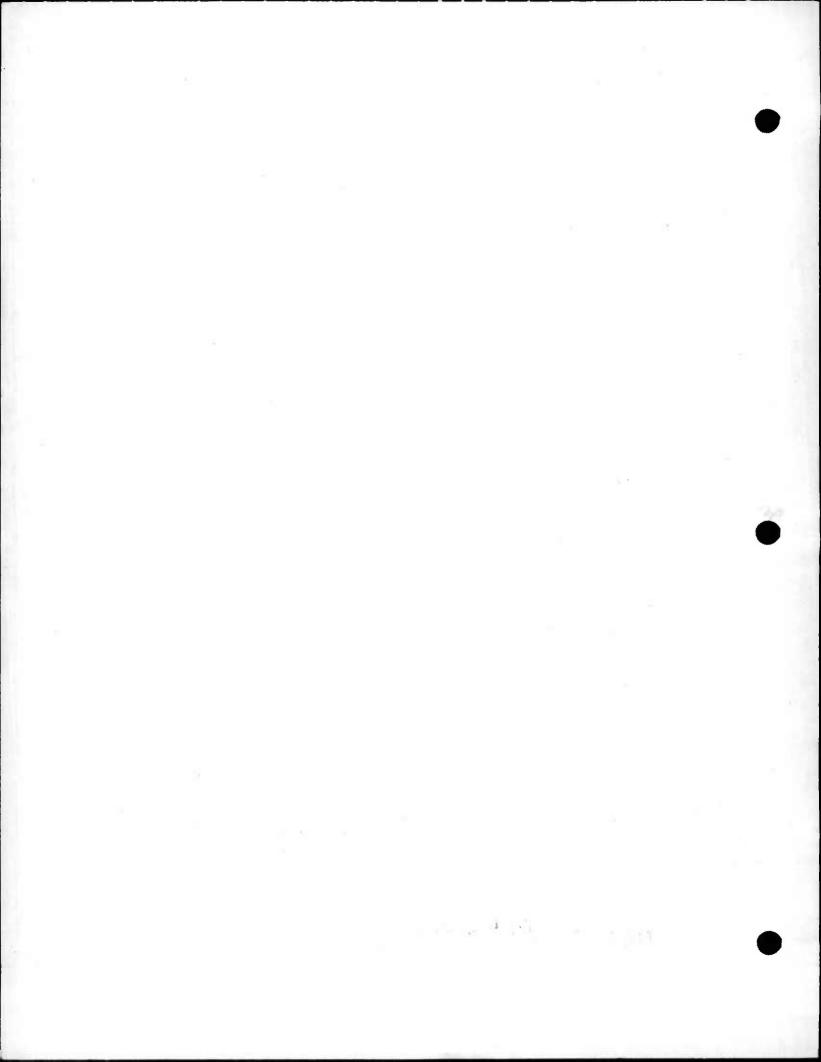
FOR STATE REGISTRAR

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DIVISION	

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH O'NEAL WILLIAM 7. DATE OF BIRTIN (Month, Day, Year) 02/19/51 :20 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 X M 2 - F 577-66-2997 ALABAMA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY WASHINGTON, D.C. NA NA the funeral director, page 5 should be detached for use as the burial-transit permit. YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2107 SHIPLEY TERRACE #203 20020 United States Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married
3 Wildowed 4 Divorced ВҰ SPECTACK. COMPLETED 15. DECEOENT'S EDUCATION 18a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12 MANAGER RETAIL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) H WILLIAM O'NEAL CATHERINE THOMAS BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HATTIE LAWSON (Aunt) 9705 Harace Harding Expressway #17J Corona,NY 11368 2 20a. METNOD OF DISPOSITION
1 ☐ Burlel 2 M Cremetion 3 ☐ Removal from State
4 ☐ Donation 6 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must cometery, crematory or other place! METROPOLITAN CREMATORIUM 4/14 ALEXANDRIA, VIRGINIA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY hours after death. ALEXANDER S. POPE FUNERAL HOMES M859 5538 MARLBORO PIKE, FORESTVILLE,MD 20747 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by Interval Batween 0 **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition executed with the Systemic Inflammatry Response Syndrome certificate has been signed by the attending physician and completely the State Dept. of Health and Mental Hygiene prior to burial, crematic event, t 12 hours resulting in death) DUE TO (OR AS A CONSEQUENCE OF): myofasciitis Necrotizing CERTIFICATION other traumatic Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING Tuired Immune Deficiency Syndrome the death certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? requires that any 1 YES 2 NO shows 1 - YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\mathbb{Z}\). UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 3W 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) Item **EXAMINER?** HOSPITAL: OTHER: 1 TYES 2 NO PHYSICIAN: 1 Ninpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Nome 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATN 28b. TIME OF INJURY 28a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this (marked, (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY After death Investigation ATTENDING 3 Suicide 28a. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be DIRECTOR: 28 4 Homicide item OR 29a. CERTIFIER 1 🔂 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner se stated, 29b. SIGNATURE AND ATTLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIONED (Month, Day, Year) D22990 4/12/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Edward Schwab, MD , Holy Cross Hospital, Silver Spring 32. REGISTRAB'S SIGNATURE 31. DATE FILED (Month, Day, Year) 14 1995 **APR**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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BALTIMORE, MARYLAND	retained
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DS, P.O. BOX 68760	the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital
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TO BE COMPLETED BY FUNERAL DIRECTOR

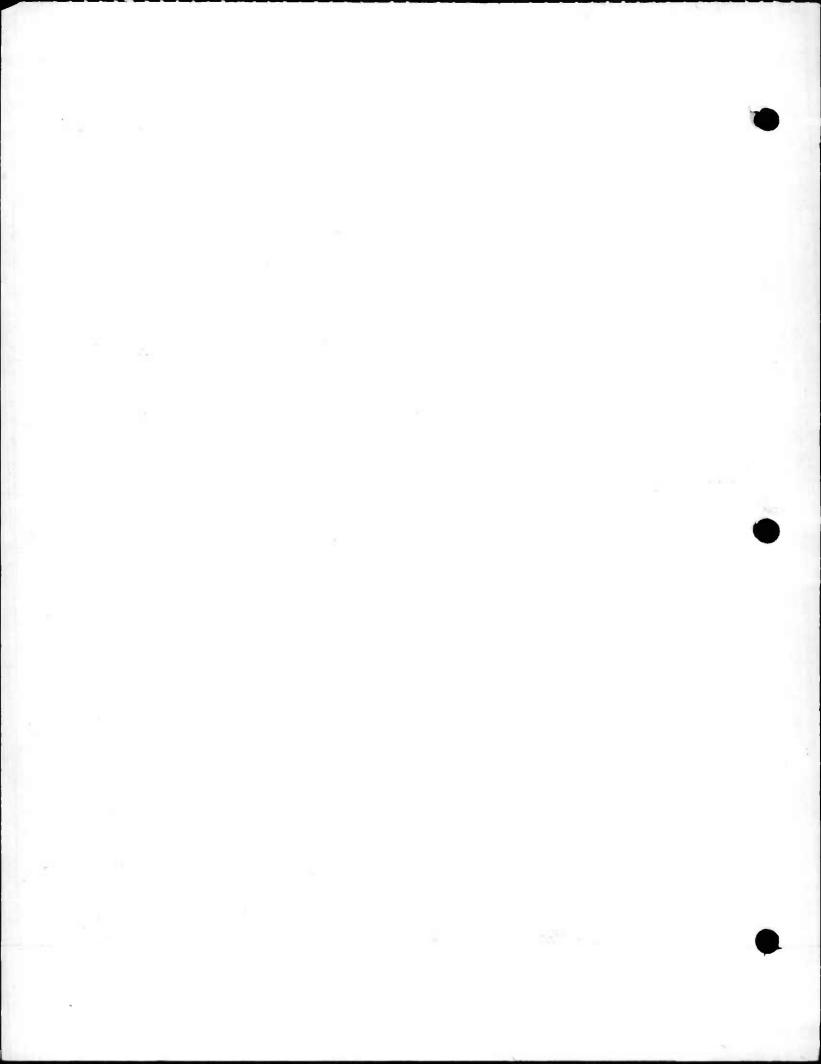
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filted to death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DE	ATH
EDWARD	J.	O'Hearn			April 17,	199	5 YEAR	6:05	А. м
4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or	Foreign
171 20-0020		ol YRS.	NTHS DAYS	HOURS MIN.	pril 7, 1	934	Penn	"sylvan:	ia
9a. FACILITY NAME (If not institution, give street	and number)	9b	CITY, TOWN C	R LOCATION OF DE		_	NTY OF DE	EATH	
5203 Fairgreene	e Way		Ijam	sville		F	rede	rick	
10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION				10d. INSIDE CIT	ΓY
	lerick	Ij	amsvil	le				1 YES 2] NO
10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITI	ZEN OF W	HAT COUNTRY	
5203 Fairgreene				21754		Uni	ted S	States	
11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No-	14. RACE Black	- American In	dian,
3 Wildowed 4 Divorced	FORCES? 1 YES	ATES	1 TYES			- [Specif		
15. DECEDENT'S EDUCATI	Korean	18a. DECEDENT'S USU	IAL OCCUPATIO	N.	16b. KIND OF BUS	1	HOTEV	WILLE	
(Specify only highest grade com	npleted)	(Give kind of work life. Do NOT use ret	done during mos	t of working	100. KIND OF BUS	SINESS/INL	USTRY		
Commentary/Secondary (0-12)	College (1-4 or 5+)	Personnel	1 Offic	rier	Gov	ernme	nt		
17. FATHER'S NAME (First, Middle, Last)		1010011110			ME (First, Middle, Maiden		.11 C		
Vincent P. O'Hea	rn				n Scanlon	ournamey			
19a. INFORMANT'S NAME (Type/Print)		19b, MAILING ADD	DRESS (Street a		Route Number, City or Tow	n. State. Zio	Code)		
Leonice Watts O'H	earn				Ijamsvill			754	
20a. METHOD OF DISPOSITION	206	. PLACEAND DATE OF DE	ISPOSITION (Ne	ne of	DATE 20c. LO				
1 Burial 2 Cremation 3 Removal Donation 5 Other (Specify)	from Stata cen	etery, cremetory or other to the Joseph's	s Cemet	ery 4	4/20/95 For	untai	n Sp	rings,	PA
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME AN	D ADDRESS OF FAC	NII 19794				
	21.		1621 0		Stauffe wn Pike F				
23. PART I. Enter the diseases, or com	polications that sausa								1702
ahock, or heart failure. List	only one cause on	ach lina.	anter the mod	ia or dying, auci	as cardiac or raspi	ratory arr	ast,	Approxir	Batwean
iMMEDIATE CAUSE (Final disease or condition	Č.	0 1	1	- cla.	1 1 1)		Onset as	10
reaulting in death)	DUE TO (OP AS 4	CALON	The	arrue	to Caro	\vee		02 M	ontu
	DOE TO (OR AS A	CONSCOURCE OF):							dr-
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
cause. Enter UNDERLYING								ĺ	
CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
resulting in death) LAST									- 1
PART ii Other cignificent conditions	antelbution to don't b								
PART ii. Other significant conditions co	bildibuting to death b	ut not resulting in tr	na underlying	cause givan in i	Part I. 24a. WAS AN PERFOR			WERE AUTOPSY AVAILABLE PRIO	R TO
					1 YES 2	No		OF DEATH?	CAUSE
					_ '			1 _ YES 2 _	NO
DID TOBACCO USE CONTRIB				UNCERTAIN	10]				
	OSPITAL:	26. PLACE OF DEATH (C	heck only one						
1 YES 2 NO 1	Inpatient 2 ER/Outp	etlant 3 DOA 4	Nursing Home		8 Other (Specify)				
Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	WOI	IK?	28d. DEŞCRIBE HOW II	NJURY OCC	URED		i
2 Accident Investigation	20. 51 105 05 10 11 11			ES 2 NO					
3 Suicide 8 Could not be determined	building, etc. (Spec	— At home, farm, atreel	t, factory, office		281. LOCATION (Street a City or Town, State)	nd Number	or Rural Ro	oute Number,	- 1
29a. CERTIFIER									
(Check only	N: To the best of my knowl								
2 MEDICAL EXAMINER: 0	on the beals of examination	and/or investigation, in	my opinion, de	ath occured at the	time, date and placa, an	d due to th	a cause(a)	and menner as	stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	0	0		29c. LICENSE NUM	BER	29d. DATE	SIGNED	(Month) Day, Year)
- John J	time	The	M	DO 718	P		111	8 9	
30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED DAUSE OF OE	ATH (ITEM 27) (Type, Ach	7	1,001	71701				
21 DATE 511 50 41 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	50110	tred	2 rict	-, Wo	21701				
31. DATE FILED (Month, Day, Year) APR 1 9 1995	32. REGISTRAR'S SIGN								



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages had suffered to the State Board of Marcel Unions price to burial committee of completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages
De men which is thous are used with the state begin, of freeing and mental hypere prior to boths. Or relieved. IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B 0

WILLIAM ROBINS,

APR 13 1995

31. DATE FILED (M

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 AEGISTRAR'S SIGNATURE

M.D.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 April 11 GERTRUDE C. Phillips 12:42 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign DAYS 2-14-1898 MARYLAND 212-01-5507 97 1 M 2 XF 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SALISBURY NURSING & REHAB CENTER DIRECTOR SALISBURY, MD. WICOMICO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. WICOMICO SALISBURY 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 608 PINE BLUFF RD. 21801 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married ВУ Specify: 3 X Widowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 NURSE HOSPITAL 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAM LEONARD CLARK MAMIE A. HORNBERGER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DICK CLARK 608 PINE BLUFF RD. SALISBURY, MD. 21801 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 1 Campail 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) SPRING CH.CEM ROCK 4-14 FOREST HILL, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD. 23 PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line intarvai Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition ____ NO 10 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reauiting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION DF CAUSE DF DEATH? PERFORMED? 1 YES 2 THO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 -DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO ВУ 2 Accident 28a. PLACE OF INJURY — At home, farm, streel, factory, office building, alc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 M CERTIFYING PHYSICIAN: To Iha beat of my knowledge, death occurred at the time, data and place, end due to the ceuse(a) end menner as atated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTURER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

1104 HEALTHWAY DR., SALISBURY,

Md.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a wours after death. Page 6 may be retained by the hospital or attending physician.

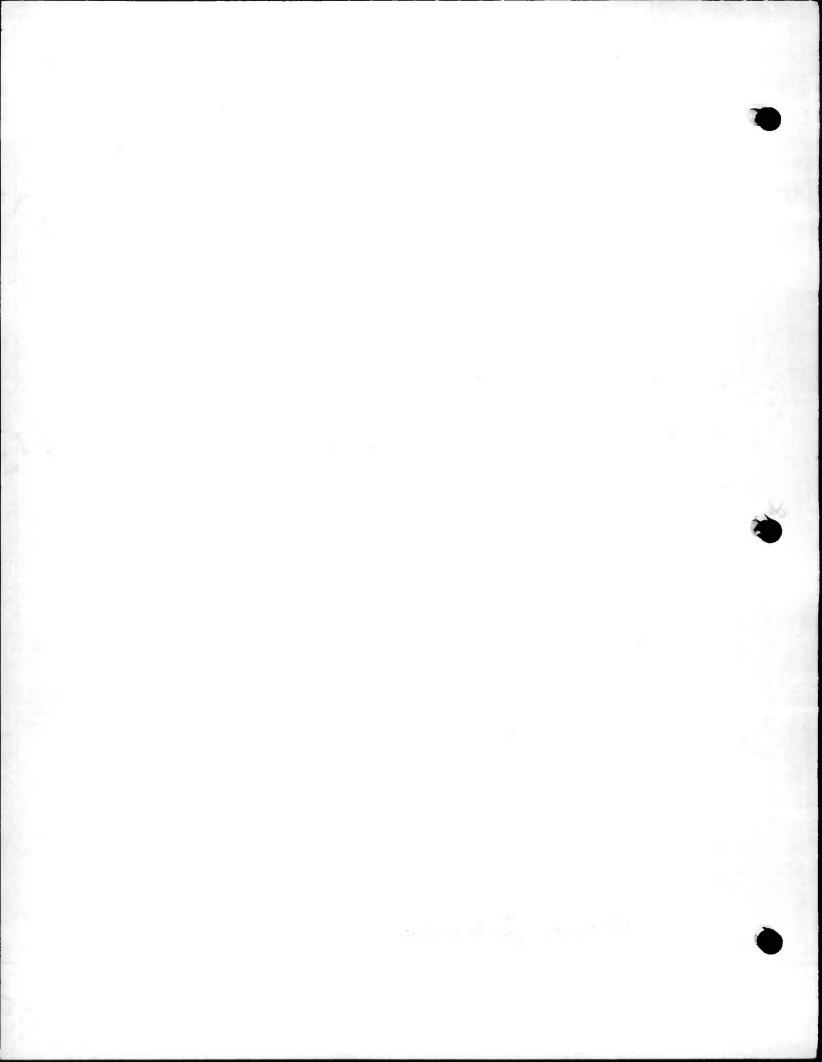
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	NEGISTRAN			Enill	CALE	T DEAL	П	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, I	ast)						2. DATE OF DEATH		3. TIME OF DEATH		
	WILLIAM	THOMAS	i I	PARKE	R		ŀ	April 14, 1995 1:			Ам	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lac	st birthday)	IF UNDER 1 YE	R IF UNDER 2	24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign	_	
	228-18-2149	69	YRS. MONTHS BAYS HO			MIN.	March 3, 1926					
	9e. FACILITY NAME (If not institution,	_	9b, CITY, TOV	VN OR LOCATIO			9c. COUNTY					
E	504 Cleveland				isbury				omico			
K	RESIDENCE OF DECEDEN			Sal	ISDUTY			Wico	omico			
DIRECTOR	10a. STATE 10b. CO	UNTY		10c, CIT	Y, TOWN OR LO	CATION			19.1	10d, INSIDE CITY		
5	Maryland W	icomico			Salisb	ıry				LIMITS?	,	
A	10s. STREET AND NUMBER					101. ZIP CODE			10g, CITIZEN	N OF WHAT COUNTRY?		
8	504 Clevelan	d Ave.				218	80.1			ISA		
FUNERAL	11. MARITAL STATUS		NT EVER IN U.S. AF	RMEO	13. WAS			C ORIGIN? (Specify Yee			_	
	1 Never Married 2 Married	FORCES?	YES 2 1	NO	If yes	specify Cuben.	, Mexican,	, Puerto Ricen, etc.)	01110-	. RACE — American Indian, Black, White, atc.		
B	3 Widowed 4 Divorced		rchant M	far in	es '	YES 2 🛣 NO	Specify:			Specify: White		
	15. DECEDENT'S		16a. OE	CECENT'S	USUAL OCCUP	ATION		16b. KIND OF BUS	INESS/INDUS			
	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	(G life	iive kind of v . Do NOT us	vork done during se retired.)	most of working	1				1	
립	10			ant i	manage	c		Ice C	ream			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			-0		FR'S NAM	E (First, Middle, Maiden			-	
	William Tho	r				rie		lson				
BE	19e. INFORMANT'S NAME (Type/Print)			b. MAII ING	ADDRESS /Stra			oute Number, City or Town		4-1		
임	Margaret M. Pa	rker	"					Salisbury				
	20e. METHOD OF DISPOSITION		20h BI 40E		OF DISPOSITION		,					
- 1	1 XBurlel 2 Cremetion 3 4 Donation 8 Other (Specify)	Removal from State	cometery, cre	ematory or of	her place)	n D a sala		DATE 20c. LOCATION — City or Town, State 4/17 Salisbury, MD				
			- I MICOH	iico i	Temor 13	al Park	C OF FACE	4/1/ Sa	lisbur	y, MD	_	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home											
	1016	taller	Nh		5	01 Sno	w Hi	11 Rd., S	alisbu	ry, MD 2180	1	
	23. PART I. Enter the diseases,	or complications the	at saused the da	ath. Do n	ot enter tha	mode of dyin	g, such	as cardiac or respi	ratory arrest			
	IMMEDIATE CAUSE (Final	ire. List only one car	use on each line	9.						Interval Batw Onset and D		
ľ	diament as an all the											
	DUE TO (OR AS A CONSEQUENCE OF):											
z												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
3												
Ē	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSE	SEQUENCE OF);								
ᇤ	resulting in death) LAST	d										
	DADT II Other electrons cond											
EDICAL	PART ii. Other significant cond				n tha underly	Ing cause gl	ven in P	art I. 24s, WAS AN. PERFOR		24b. WERE AUTOPSY FINDS AVAILABLE PRIOR TO	NGS	
8	- FULMON	YARY	F100	LI				1 YES 2	No	COMPLETION OF CAUS OF OEATH?	E	
ME										1 TES 2 NO	- 1	
	DID TOBACCO USE CO	NTRIBUTE TO CA	USE OF DEA	TH YE	S NO	UNCE	RTAIN		_			
×.	25. WAS CASE REFERRED TO MEDICA EXAMINER?		26. PLAC	E OF DEAT	H (Check only o	ne)					\neg	
Sic	1 TES 2 PNO	HOSPITAL:	☐ ER/Outpatient 3	□ DOA	OTHER:	lome 5 Real	idence 6	Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF	INJURY	26b. TIME	E OF 28c.	INJURY AT		28d. DESCRIBE HOW IN	JURY OCCUR	ED	\dashv	
	1 Natural 5 Pending	(Month, E	Jay, Year)	ILMI	4.4	WORK?	NO				- 1	
B	2 Sulalda	28e. PLACE C	F INJURY At ho	me, farm, a			1.1	28f. LOCATION (Street e	nd Number or F	Rural Bouta Number	\dashv	
COMPLETED	4 Homicide 8 Could not determine	bullding.	etc. (Specify)					City or Town, Stete)		in at 1 toute trumpy,	- 1	
"	29e. CERTIFIER		0 M - 5 V C S C								\dashv	
물											- }	
0												
ÖΙ					296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296							
									290. UAIE SI	GNED (Month, Day, Year)		
BE	29b. SIGNATURE AND TITLE OF CERT	IFIER All	, 1.0	-			916		▶ 4//	GNED (Month, Day, Year)		
		IFIER All	SE OF OPATH (ITE	м 27) _{(Туре,}	Print)	Da	916	8	1/1	8/95		
TO BE	296. SIGNATURE AND TITLE OF CERT 30. NAME AND ADDRESS OF PERSON 5/2/20 10. NAME AND ADDRESS OF PERSON	IFIER All	SÉ OF OBATH (ITE	M 27) (Type,	Print)	Da	916	8	1/1	8/95		
TO BE	30. NAME AND ADDRESS OF PERSON 31. DATE FILED (MORPH COR, Your)	WHQ COMPLETED CAU USULGE	SÉ OF OBATH (ITEI	Sa	Print) lest	Da	916		1/1	8/95		

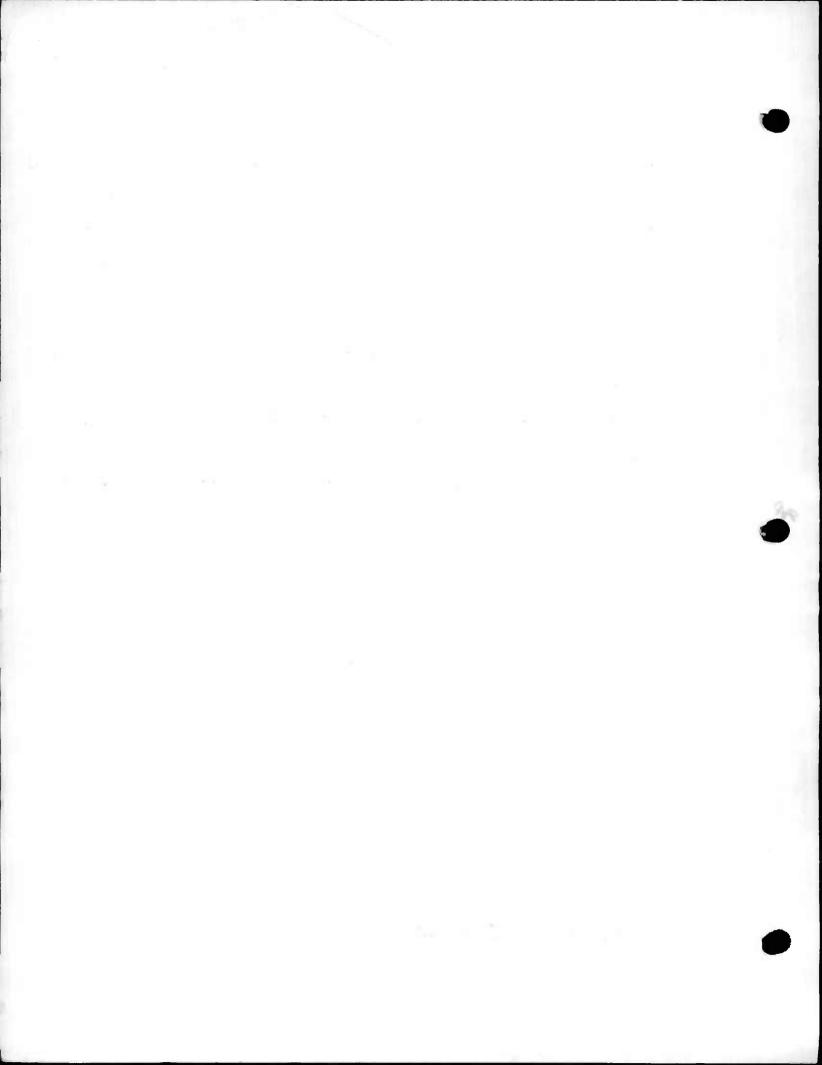


BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF HERTIFICATE OF		ENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)	2 1.		2	DATE OF DEATH	Y YEAR	3. TIME OF DEATH					
	Kobert Lee	Par Ks			0	5 1995	- 7:15 PM					
		5. SEX 6. AGE (In yrs. las	MONTHS DAYS	IF UNDER 24 HRS. 7	(Month, Day, Year)	8, BIF	RTHPLACE (State or Foreign					
	90. FACILITY NAME (If not institution, give stre	1 DM 2 F 73	YRS.	OR LOCATION OF DEAT	April 17	1921 NO	orth Carolina					
E	112 Oak St	or and namoory	E	Hand		1.11	omico					
اق	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		10c, CITY, TOWN OR LOCA				10d. INSIDE CITY					
DIRECTOR	MD Wie	comico	Fruitl	and			LIMITS?					
	10e. STREET AND NUMBER	1		. ZIP CODE		10g. CITIZEN O	OF WHAT COUNTRY?					
FUNERAL	112 Oak S			21821	0	US	>, A					
E	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2	fo if yes, sp	ENGENT OF HISPANIC ecity Cuban, Mexicon, I		В	ACE — American Indien, llack, White, stc.					
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 🗆 YES	2 NO Specify:		Sį	Black					
	15. OECEDENT'S EDUC/ (Specify only highest grade of	ompleted) (G	CEDENT'S USUAL OCCUPATI		166. KIND OF BUS	SINESS/INDUSTR	Y					
COMPLETED	Elementery/Secondery (0-12)	College (1-4 or 5+)	Do NOT use retired.)	1	Solf	8	- lound					
OM	17. FATHER'S NAME (First, Middle, Last)		Carpenic	16. MOTHER'S NAME	(First, Middle, Maiden	Surname)	ADIOGEO					
BE C	Arthur P.	arks		Mary	Wel	ch						
TO B	19e. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADDRESS (Street	and Number or Rural	ite Number, City or Tow	n, State, Zip Code;)					
-	Inell Pa	rks	112 Oak 5	of tr	uitland,	MU	21826					
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	val from State 20b. PLACE other pl	S 0	Maranary or	20c. LO	CATION - City of	r Town, State					
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE /	20: NAME A	ND ADDRESS OF FACIL	TY 1	Dace	CALVINL.					
	* alvin I.	Williams	3	10 Fred	In Iton	2122	y WILLIAMS					
	23. PART I. Enter the diseases, or co	omplications that caused the de	eath. Do not entar the mo	2011	aa cardiac or reap	iratory arrest,	Approximate					
	ahock, or heart feilure. L IMMEDIATE CAUSE (Finel	lst only one ceuse on each line					Interval Between Onset and Dasth					
	disease or condition resulting in death) a. Metristate Carel											
	DUE TO (OR AS A CONSEQUENCE OF):											
NO NO	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
CAT	ceuse. Entar UNDERLYING											
TIF	CAUSE (Disease or Injury that initiated events resulting in daath) LAST	DUE TO (OR AS A CONSE	OUENCE OF):									
CERTIFICATION	d d											
CAL	PART II. Other algnificant conditions	contributing to death but not	reaulting in the underlyir	g ceuse given in Pr	art I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO					
	COPI				1 YES :	NO	COMPLETION OF CAUSE OF DEATH?					
ME					-	^	1 YES 2 NO					
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL		28. F	LACE OF DEATH (Check	k only one)							
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	OTHER:	ne 5 Reeldence 6								
Ή	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. IN		284. OESCRIBE HOW	NJURY OCCURE	D					
ВУ Б	1 Return 5 Pending investigation	(Month, 20), Youry		YES 2 NO								
	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, factory, offi	2	28f. LOCATION (Street City or Town, State		iral Route Number,					
Ш	20- CERTIFIED											
COMPLETED	(Check only	CIAN: To the best of my knowledge, de					use(e) end menner ee stated.					
	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. LICENSE NUMBER 29d. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											
BE	1750			127	46	▶ ?	417/55					
۵/	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITE				/						
	Igranal C	- J. Na do	M-1			,						
	31. DATE FILED (Month, Day, Year)	32 AEGISTRAR'S SIGNATURE	really									



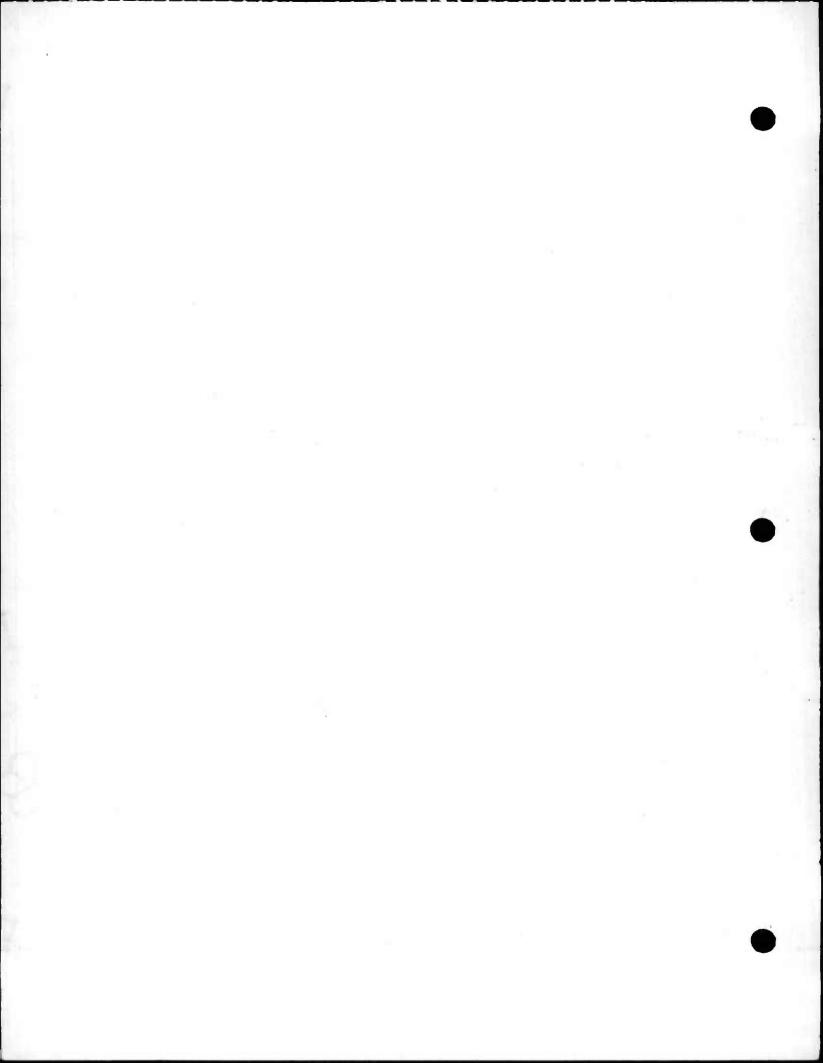
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S, P.O. BOX 68760	death certificate be executed with
DS, P.O. BOX 68760	the death certificate be executed within
JRDS, P.O. BOX 68760.	hat the death certificate be executed within
CORDS, P.O. BOX 68760	es that the death certificate be executed within
RECORDS, P.O. BOX 68760	requires that the death certificate be executed within
AL RECORDS, P.O. BOX 68760	the law requires that the death certificate be executed within hours after death. Page 6 may be retained by the bosonial or attending the law requires that the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the bosonial or attending to the law received by the law receive

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withis. Thours after death, Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic avent the market.

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	FOR 1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	TMENT OF	HEALTH AND I	MENTA	L HYGIEN	E		
	1. DECEOENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH			3. TIME OF DEATH
	Reba	G. Parc	doe				Apri	Ï 25, 19	95	YEAR	550 A M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH	,		PLACE (State or Foreign
	215 26 2334	1 🗌 M 2 🔀 F	80	YRS.				¹ 13, 191	4	vairy I	
DIRECTOR	9a. FACILITY NAME (If not institution, give Solamons Nursing Center RESIDENCE OF DECEDENT				Solaran	OR LOCATION OF DE	EATH			vert	EATH
S	10a. STATE 10b. COUNT	ry		10c. CIT	Y, TOWN OR LOCA	ATION			-	Т	10d. INSIDE CITY LIMITS?
	Maryland Calve	rt		Lus	-	01. ZIP CODE			10. 0171		LIMITS? 1 YES 2 NO HAT COUNTRY?
FUNERAL	12825 McCready Road	Laura				20657			Uni	ted S	tates
5	1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 2X N	O	If yes, s	CENDENT OF HISPAN pocify Cuban, Maxica	n, Puarto		or No-		- American Indian, White, atc.
D BY	3 € Widowed 4 Divorced	IF YES, GIVE WAR				S NO Specify					white
COMPLETED	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Given life)	ve kind of v Do NOT us		nost of working	168	. KIND OF BUS			
M P	11		cle	endk gr	coery Sta	are		retail	sale	S	
	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA			Sumame)		
B	J. Frank Elliott 19a. INFORMANT'S NAME (Type/Print)		-			Hattie V					
TO BE	Suzanne P. Cibulay		12	2825 N	foCready I	Rd. P.O. Bo	x 584				0657
	20a. METHOD OF DISPOSITION Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from Stata	20b. PLACE A CEMPLEY, CYPE MICHIENE	no date o	her place temper	tery April 2	7, 99		Calv		on, Stata aryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. NAME A	AND ADDRESS OF FA	CILITY	ausch Fi	neral	Home	P.A.
CXG	DKO	400				roomes Is.	Rd. P	Ort Rep	blic	Maryl	
anica	23. PART i. Enter the diseases, or ahock, or heart fallure.	complications that c	ausad the dea	ath. Do n	ot anter the m	ade of dulpa evol	h ac can	diac or respi	ratory arr	est.	Approximata
-					oc antor tha m	oua or dying, auc	ii ao car	op	atory arr		
2	IMMEDIATE CAUSE (Final	A-	on each line.		ot anter tha m		ii as car		atory and	,	Interval Between Onset and Death
1, 116	IMMEDIATE CAUSE (Final disease or condition reaulting in death)	0	, (A					Intarval Batween
atent, me	disease or condition	0	, (n drome					Intarval Batween
ION	disease or condition reaulting in death) Sequentially list conditions,	a. Orga DUEDO (OI b. Diab	, (O CA	in sy	A					Intarval Batween
CATION	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. Orga DUE TO (OI	niè l R AS A CONSEO ctes	O CA	in sy	A					Intarval Batween
IFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. Organ DUE TO (OI C.	niè l R AS A CONSEO ctes	O CA WENCE OF	1 sy	A					Intarval Batween
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. Organ DUE TO (OI C.	R AS A CONSEO	O CA WENCE OF	1 sy	A					Intarval Batween
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- U	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	a. Due to (or our to (or d	R AS A CONSEO	DICE OF	n tha underlylr	n chome	Part I.	24a. WAS AN	AUTOPSY	24b.	Interval Between Onset and Death S Y C J J O Y C S S S S S S S S S S S S S S S S S S
- U	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	a. Due to (or oue to (or d	R AS A CONSEO R AS A CONSEO R AS A CONSEO Beath but not ra	DICE OF	n tha underlylr	n chome	Part I.	24a. WAS AN	AUTOPSY	24b.	UNITED AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
- U	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other aignificant conditions DID TOBACCO USE CONT	a. Due to (or our to (or d	R AS A CONSEO R AS A CONSEO R AS A CONSEO Beath but not ra SE OF DEAT 26. PLACE	UENCE OF	The underlying the Check only one of the Check only one of the control of the con	n chome	Part I.	24e. WAS AN PERFOR	AUTOPSY	24b.	UNITED AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES PANO 27. MANNER OF DEATH	a. Due To (or oue to (R AS A CONSEO R AS A CONSEO R AS A CONSEO R AS A CONSEO 26. PLACE R/Outpetlant 3	UENCE OF UENCE OF UENCE OF DEATH	The state of the s	n do ome	Part I.	24e. WAS AN PERFOR	AUTOPSY MED? NO	24b.	UNITED AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
- U	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES PANO	a. DUE TO (OI b. DUE TO (OI c. OUE TO (OI d. HOSPITAL: 1 Inpetiant 2 E 26a. DATE OF IN. (Month, Day.	R AS A CONSEO R AS A CONSEO R AS A CONSEO Beath but not ra 26. PLACE (R/Outpetlant 3) (R/Outpetlant 3)	UENCE OF DEAL PLANTS INJ	The state of the s	unchome To ause given in UNCERTAIN Diagram 5 Raaldenca	Part I. N	24a. WAS AN PERFORM 1 YES 2 per (Specify) SCRIBE HOW IN	AUTOPSY MEO? NO	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES SONO 27. MANNER OF DEATH 1 Natural 5 Pending	a. DUE TO (OI b. DUE TO (OI c. OUE TO (OI d. TRIBUTE TO CAUS HOSPITAL: 1 Inpetiant 2 E 28e. DATE OF IN.	R AS A CONSEO R AS A	UENCE OF DEAL PLANT	The state of the s	unchome To ause given in UNCERTAIN Diagram 5 Raaldenca	Part I. 8 Othe 26d. 0E:	24a. WAS AN. PERFOR 1 UYES 2	AUTOPSY MEO? NO	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES SONO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	a. DIE TO (OI b. DIE TO (OI c. OUE TO (OI d. Ina contributing to de RIBUTE TO CAUS HOSPITAL: 1 Inpetiant 2 E 26a. DATE OF IN. (Month, Day, 26b. PLACE OF II building, etc	R AS A CONSEO R AS A CONSEO R AS A CONSEO R AS A CONSEO 26. PLACE R/Outpetlant 3 JURY Year) NJURY — At hom 2. (Specify)	UENCE OF UEN	The underlying the control of the co	uncertain Uncertain Uncertain Uncertain Uncertain Uncertain Uncertain Uncertain Uncertain Uncertain Uncertain	Part I. 6 Other 26d. OE:	24a. WAS AN PERFORM 1 YES 2 PERFORM 1 YES 2 PERFORM PE	AUTOPSY MED? NO	24b. URED or Rural Ro	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES SONO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	a. Due To (of Due To (R AS A CONSEO R AS A	UENCE OF UENCE OF DEAT DOA 1NJ	The treet, factory, officet, tactory, officed at the time, det	ng cause given in VINCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN ORK? YES 2 \(\) NO ca	Part I. 8 Other 26d. 0E: 26f. LOC City	24a. WAS AN. PERFOR 1 YES 2 OF (Specify) SCRIBE HOW IN CATION (Street a. or Town, State)	AUTOPSY MED? NO NO NURY OCC and Number	24b. URED or Rural Ro	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL C	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIER	a. DUE TO (OI b. DUE TO (OI c. OUE TO (OI d. Ina contributing to de RIBUTE TO CAUS HOSPITAL: 1 Inpetiant 2 E 26a. DATE OF IN (Month, Day, 26a. PLACE OF II building, etc	R AS A CONSEO R AS A	UENCE OF UENCE OF DEAT DOA 1NJ	The treet, factory, officet, tactory, officed at the time, det	ng cause given in VINCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN ORK? YES 2 \(\) NO ca	Part I. 8 Other 26d. OE: 26f. LOC City to the care time, data	24a. WAS AN. PERFOR 1 YES 2 OF (Specify) SCRIBE HOW IN CATION (Street a. or Town, State)	AUTOPSY MEO? NO NO NO NO NO NO NO NO NO	24b. URED or Rural Ro	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2500 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER LANGE UNDER CONTINUE CONT	a. DUE TO (OI b. DUE TO (OI c. OUE TO (OI d. TRIBUTE TO CAUSTILE T	R AS A CONSEO R AS A	UENCE OF UENCE OF UENCE OF UENCE OF DEATH OF DOA 28b. TIMINJ	The state of the s	ng cause given in UNCERTAIN THE S Raildenca JURY AT ORK? YES 2 NO ca a and place, and due death occured at tha	Part I. 8 Other 26d. OE: 26f. LOC City to the car time, data	24a. WAS AN. PERFOR 1 YES 2 OF (Specify) SCRIBE HOW IN CATION (Street a. or Town, State)	AUTOPSY MEO? NO NO NO NO NO NO NO NO NO	24b. URED or Rural Ro d. a cause(a)	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL C	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIER	a. Due To (of Due To (R AS A CONSEO R AS A	UENCE OF UEN	The treet, factory, officed at the time, dat in, in my opinion,	UNCERTAIN UNCERTAIN TORK? YES 2 NO TORK? TORK.	Part I. 8 Other 26d. OE: 26f. LOC City to the car time, data	24a. WAS AN J. PERFORM 1 YES 2 or (Specify) SCRIBE HOW IN CATION (Street as or Town, State) use(a) and menual and place, and	AUTOPSY MEO? NO NO NO NO NO NO NO NO NO	24b. URED or Rural Ro od. a cause(a) SIGNED (WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in dasth) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES PNO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER CHECK ONLY ONE) 2 MEDICAL EXAMINITY. 30. NAME AND ADDRESS OF PERSON WE	a. Due To (of Due To (R AS A CONSEO R AS A	UENCE OF UENCE OF UENCE OF UENCE OF DEAT DOA 28b. TIMINJ Inc., farm, a	The treet, factory, officed at the time, dat in, in my opinion,	UNCERTAIN UNCERTAIN TORK? YES 2 NO TORK? TORK.	Part I. 8 Other 26d. OE: 26f. LOC City to the car time, data	24a. WAS AN J. PERFORM 1 YES 2 or (Specify) SCRIBE HOW IN CATION (Street as or Town, State) use(a) and menual and place, and	AUTOPSY MEO? NO NO NO NO NO NO NO NO NO	24b. URED or Rural Ro od. a cause(a) SIGNED (WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	95-1990-005										0.0		3602)
	blh ITEM	S: 23 PART I,	27, PER	MEO F	ILM G	-723	5/19/	95 t.	t		9.		10002	•
	FOR 1 - STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	F OF H	EALTH DEAT	AND TH	MENTAI	HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Li	est)							2. DATE	OF DEATH		YEAR	3. TIME OF DEAT	Ή
	Donnell	Hershe			Parr	an				il 08			0623	М
	4. SOCIAL SECURITY NUMBER 219-78-7649		8. AGE (In yrs. las		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE	OF BIRTH , Day, Year)		8. BIRTH Count	HPLACE (State or Fo	reign
	9e. FACILITY NAME (If not institution, g	1 💢 M 2 🗆 F	33	YRS.						. 20,1			ington,	D.C.
Œ							OR LOCATION		EATH			INTY OF D		
210	Northwest Medic				Ran	dals	town				Ba.	Ltimo	re	
DIRECTOR	Monay land	JNTY			Y, TOWN		ION						10d. INSIDE CITY	
0 7	Maryland 100. STREET AND NUMBER			Ва	1tim						,		1 X YES 2 _	NO
RA	3701 Twin Lake	s Court Ant	- 201			101	ZIP CODE				10g. CIT		WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13.	WAS DEC			NIC OBIGIN	? (Specify Yes	or No.	USA		
BY FI	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1	YES 2TA	10		If yes, sp	city Cubs	n, Mexico	n, Puerto F	tican, etc.)	or No		E — American India k, White, etc.	m,
ED	15. DECEDENT'S I (Specify only highest g	EDUCATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		16b.	KIND OF BUS	SINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	vork done	during mo	st of working	g						
MP	12	2	L	abor	er		_			Constr		on		
8	17. FATHER'S NAME (First, Middle, Last) Maurice		0 1				_		ME (First, A	fiddle, Maiden				
BE	19e. INFORMANT'S NAME (Type/Print)		Gudger	MAILING	ADDRESS	2 (Otmat a	Ove		Courts Alicent	er, City or Town		rran		
5	Oveta Watkins						St.			on, MD		/		
	20a METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 F	lemoval from State	20h DI ACE A	MODATES	AF DIEDOG	ATION (A)							rwn, State	
	4 Donation 5 Other (Specify) _ 21. SIGNATURE OF FUNERAL SERVICE		St. Ed	mond	UM (Chr.	Cem	. 4/	13/95	Che	sape	ake :	Beach, M	D
	1	LICENSEE			1	INAME AIR	O ADDRES	33 OF FA	CILITY	Sewell	Fun	eral	Home	
	spercer	4. Se	uel	<u>l</u>	1								erick, M	D
	23. PART I. Enter the disesses, shock, or heart failu	or complications that re. List only one caus	caused the da	ath. Do n	ot antar	tha mo-	ds of dyi	ng, suc	h as card	isc or respi	ratory sr	rest,	Approxima	
	iMMEDIATE CAUSE (Final disease or condition												Onset and	
	resulting in death)		OR AS A CONSEC		η.									
z					,									
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	HIENCE OF	7:		1.0						1	
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or Injury	C. DUE TO U	OR AS A CONSEC	HENCE OF										
E	that initiated events resulting in death) LAST	302.00	on no n compe	TOLITOL OF	,.								İ	
핑	DART II ON THE STATE OF												1	
정	PART II. Other significant condit	ions contributing to d	leath but not re	esuiting i	n tha un	dariying	cause g	iven in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FII AMILABLE PRIOR	ro
										1 YES 2	□ NO		OF DEATH?	AUSE
Σ.	DID TOBACCO USE CON	STRICT CAL	ISE OF DEV	TLI VE	c \square k	10 F	LINIC	ERTAI		, .			1 YES 2 N	10
AN	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT			UNC	EKIAII	ч 🗆]					
SIC	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Re-	eldence	8 🗆 Other	(Specify)				
PHYSICIAN: MEDICAL	27. MANNER OF DEATH 1 XX Netural 5 Pending	28e. DATE OF II (Month, Day	NJURY (Year)	28b. TIMI	-	28c. INJI WO	JRY AT			CRIBE HOW IN	NJURY OC	CURED		
ВУ	2 Accident Investigation	28a PLACE OF	INJURY — At hor	ne, farm, a			ES 2	NO	201 1 004	TION (Street e	ad Mumba	a or Burnt C	Parata Miranhar	
TED	4 Homicide B Could not determined	i building, e	tc. (Specify)		.,	,, -,,,,,,			City o	r Town, State)	reditions	. u norai r	vare reamber,	
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PH	YSICIAN: To the best of m	ny knowledge, des	th occurre	d at the ti	me, date	end place.	end due	to the ceur	le(e) end men	ner ee ete	ted.		
OM		INER: On the basis of ass) end manner es st	sted.
BE C	296 SIGNATURE AND TITLE OF CENTRE		A)				29c, LICE	NSE NUM	ABER		29d. DAT	E SIGNED	(Month, Day, Year)	\dashv
- 1	*V (\ /)	LTIXA	1 74				_							

290 SIGNATURE AND TITLE OF CENTIF		ATT
20 NAME AND ADDRESS OF PERSON WAS	tous	ITM

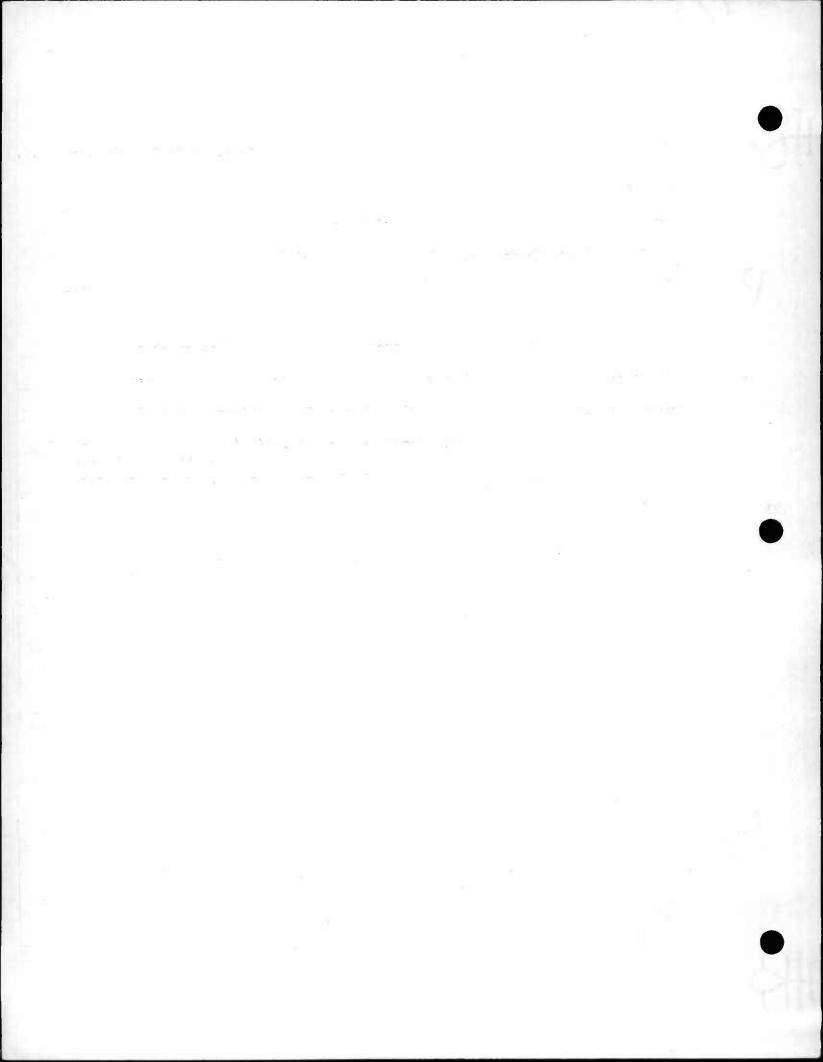
9

29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Day, Year) April 09 1995

TH (ITEM 27) (Type, Print)

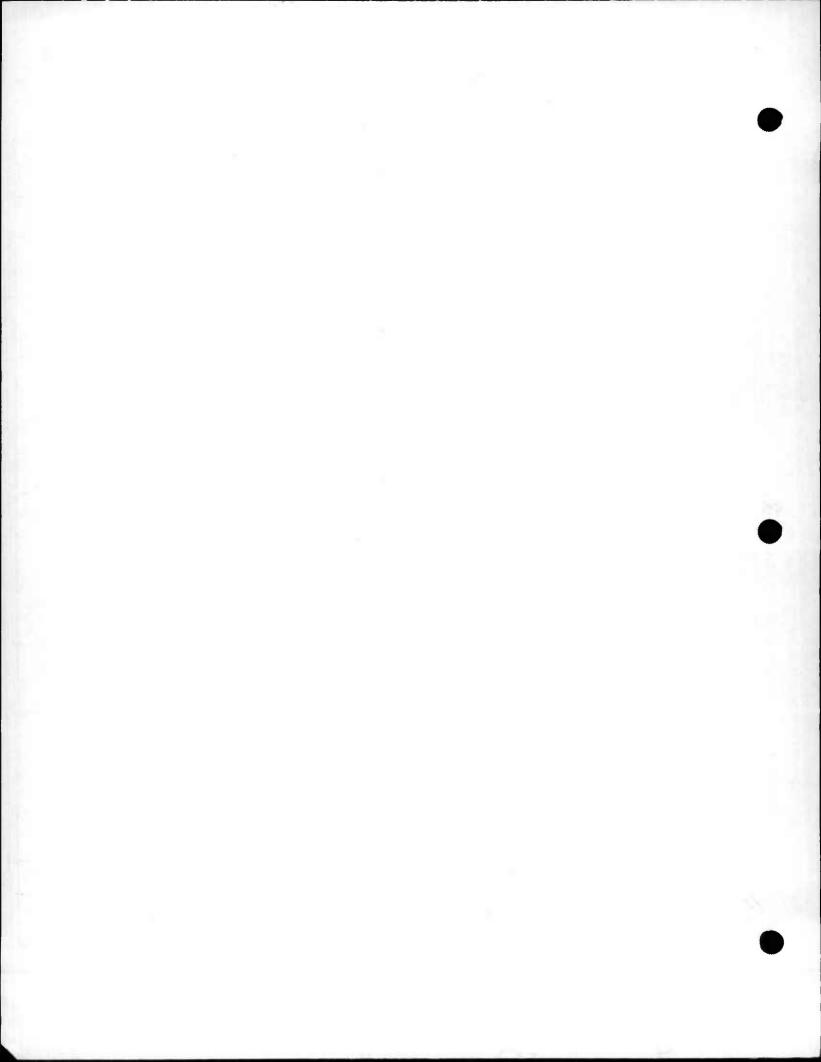
Penn Street, Baltimore Maryland 21201 31. DATE FILED (M

32 REGISTRAR'S SIGNATURE APR 1995 9



	1 - FOR STATE REGISTRAR	STATE OF A	MARYLAND /	DEPAR ERTIF					MENT	AL HYGIEN	E		
	1. DECEOENT'S NAME (First, Middle, Last)	ulter	•	PA	THE	SN,	S	R.	2. DAT	TE OF DEATH	18	95	3. TIME OF OEATH 2 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	DAYS	IF UNDER	R 24 HRS.		E OF BIRTH		8. BIRTHP	LACE (State or Foreign
	248-46-5485	1X M 2 F	60	YRS.		DATE	ноона	With.	Apr	26, 19	934		n Carolina
~	90. FACILITY NAME (If not institution, give st 3916 TRITON COL				9b. CIT	, TOWN C	R LOCATI	ON OF DE	EATH		9c. COU	NTY OF DE	ATH
Ē	RESIDENCE OF DECEDENT				TE	MPLE	HIL	LS			PRI	NCE G	EORGES
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
		ce George	es	Ter	nple	Hil:	ls				_		LIMITS?
FUNERAL	3916 TRITON COURT	r				101	ZIP COD	€ 20748	8				STATES
3	11. MARITAL STATUS	12. WAS OECEDEN	T EVER IN U.S. AR	MED	13.	WAS OEC	ENDENT (OF HISPAN	NIC ORIG	IN? (Specify Yes			
	1 Never Merried 2 Married	FORCES? 1 IF YES, OIVE W	YES 2 N	10		it yes, spe	city Cubi	ın, Mexice	n, Puerte	o Rican, etc.)			- American Indien, White, etc.
ВУ	3 Widowed 4 Divorced		-174-1				- LAT.10	opoon	,			B	LACK
臣	15. DECEOENT'S EDUC (Specify only highest grade	CATION completed)	18e. DE	CEDENT'S	USUAL O	CCUPATIO	N st of workii	na	11	b. KIND OF BUS	SINESS/INI	DUSTRY	
Ë	Elementary/Secondary (0-12)	College (1-4 or 5 -	1)	Do NOT us				- 4					
COMPLETED	12		CA	RPENT	LEK .					ONSTRU		<u> </u>	
	17. FATHER'S NAME (First, Middle, Lest) WALTER PATTON									, Middle, Maiden	Surname)		
BE	19e. INFORMANT'S NAME (Type/Print)							SIE	BAN				
임	SHIRLEY PATTON									mber, City or Town			
	20e. METHOD OF DISPOSITION							, IE	_	HILLS			
	1 N Burial 2 Cremelion 3 Remo	oval from Stale	20b. PLACE A cometery, cre. CEDA	matory or o	ther place)	SITION (Nai	me of CDV		1			City or Tow	
	21. SIONATURE OF THISRAL SERVICE UC	ENSEE	- CLDAI	X IIII	7	NAME AN		SS OF FA		14] 50.	LILAN	VII), MI	ARYLAND
	Mugs	Hone &	3	M859	5	5538	MARI	LBORG) PI	E FUNEI	RESTV	ILLE.	, MD 20747
	23. PART I. Enter the diseases, or c shock, or heert fellure. I	omplications that	ceused the de	ath. Do r	ot enter	the mod	de of dy	ing, suc	h es ce	rdiec or reepi	ratory an	rest,	Approximete
	iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	Arter	(OR AS A CONSEC	tu		rde	ora	cer	lar	dis	ear	22	Interval Between Onset end Death
N	Sequentially list conditions,	3	(OR AS A CONSEC	JUENCE UI	r):								
CERTIFICATION	If any, leeding to immediate ceuse. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	DUENCE OF	f):								
윤	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	F):								-
E	resulting in death) LAST	4			•								
		14											1
PHYSICIAN: MEDICAL	PART II. Other significant conditions	s contributing to	deeth but not re	esulting	n the ur	nderlying	cause	given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	1	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M												1	☐ YES 2 ☐ NO ·
Z	DID TOBACCO USE CONTR	IBUTE TO CA			S		UNC	ERTAIN	4 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMPLER?	HOSPITAL:	28. PLAC	E OF DEAT	H (Check								
YS	1 PYES 2 NO	1 Inpatient 2 I		□ DOA			5 DA	sidence	8 🗆 011	ner (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF (Month, Da		28b. TIMI INJ	E OF URY M	28c. INJU WOI 1 Y	IRY AT RK? ES 2	NO	28d. DI	EŞCRIBE HOW II	JURY OC	CUREO	
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — Al horetc. (Specify)	me, farm, a	itreet, feci	ory, office			28f. LO Cit	CATION (Street e y or Town, State)	nd Number	or Rural Ro	ute Number,
<u></u>													
COMPLETED	(Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	SIAN: To the best of	my knowledge, der	nth occurre	d at the t	lme, date	and place,	and due	to the co	euse(e) end man	ner en stel	led.	
8		_		rivestigatio	n, in my c	pinion, de	with occur	ed at the	time, da	te end place, end	due lo th	ne ceuse(e)	and menner ee stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER	0 (0)	1000	_ 12	110		29c. LICE	NSE NUM	BER	20	29d. DAT	E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON AND	COMPLETED CALL	ugue	3/11	5		500	di	10	30	11	Bul	10, 1995

A RECISTRAR'S SIGNATURE



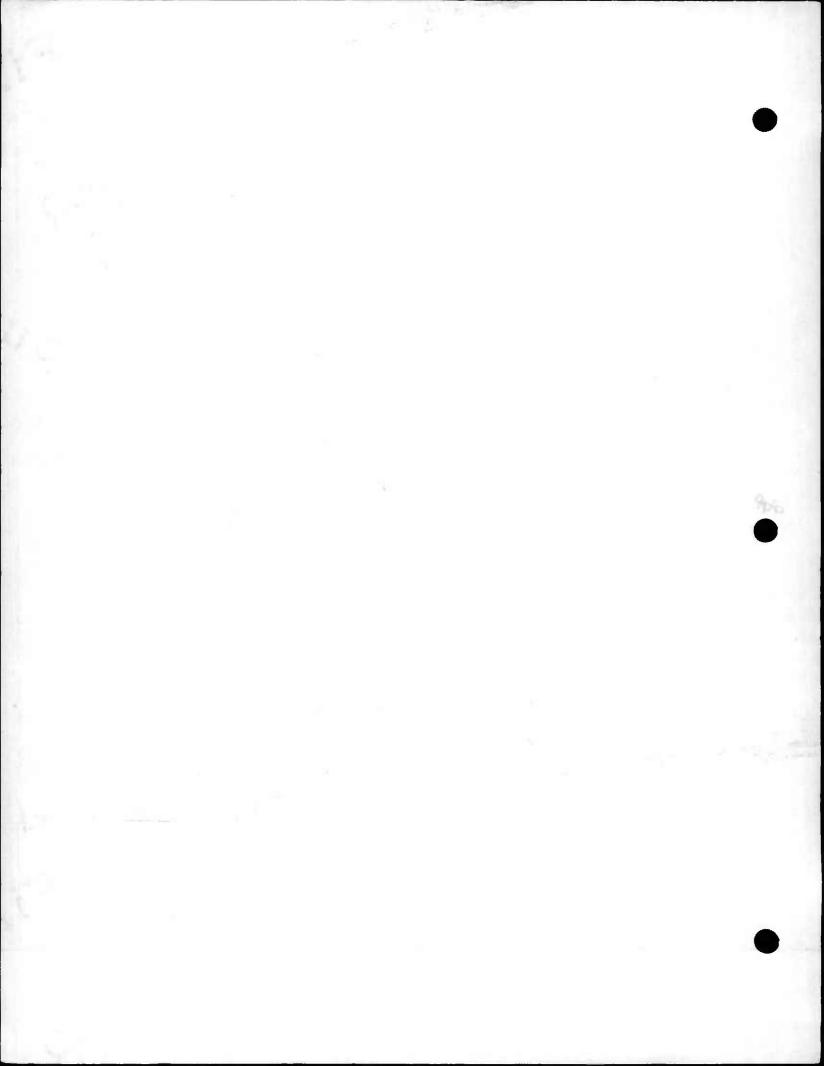
DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020	age 6 may be retained by the hospital or attending physicia
BALTI	er death. Pa
de	ours an
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

1 - FOR STATE REGISTRAR

100		1. DECEDENT'S NAME (First, Middle, Last)	4.4				2. DATE OF DEATH MONTH	DAY YI	3. TIME OF DEATH
,		MABLE	H.	PRICE	5		APRIL	7 199	
		4. SOCIAL SECURITY NUMBER	\ \ /	(In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
목		578-20-6221		O YRS.		3.00	9-5-19	114 7	Domas n.C.
should	ar I	9s. FACILITY NAME (If not institution, give	street and number)	+1	9b. CITY, TOWN	OR LOCATION OF	DEATN	9c. COUNTY	OF DEATH
6,	ē	RESIDENCE OF DECEDENT	ventut Hos	selde	monl	gomany	Courtes	More	Jomore
ges 1	DIRECTOR	10e. STATE 10b. COUNT	Y	10c. CI	TY, TOWN OR LOC	ATION		- 6	10d. INSIDE CITY
æ .≕	ă	my. D	, G.	1	untler	ill m	neland		1 YES 2 NO
permit	AL	10e. STREET AND NUMBER	1	- 10	1	OI. ZIP CODE	1	10g. CITIZEN	OF WHAT COUNTRY?
	FUNERAL	1117- Cakda	e Dr. Hu	attsville	md	20787	2	U	S.
pnysician. burial-transit	2	11, MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DE	CENDENT OF HISP	ANIC ORIGIN? (Specify Young, Puerto Ricen, atc.)	ee or No- 14.	RACE — American Indian, Black, White, etc.
the bu	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	OATES	1 🗆 YE	S 2 NO Spec		1.	Specify: QQ . I
as as	ED I	15. DECEDENT'S EDU	ICATION	18e. DECEDENT	S USUAL OCCUPAT	TON	TO LOC	USINESS/INDUS	Beack
for use		(Specify only highest gradi Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT	work done during n	nost of working	100. KIND OF BI	JSINESS/INDUS	INT
spirasi ned fo	교	10-1%	College (1-4 or 5+)	nu	180) (U	do	Hono	ital.	
detach	COMPL	17. FATHER'S NAME (First, Middle, Last),	1	7 -07 12		18. MOTNER'S N	AME (First, Middle, Maide	n Surname)	
8 6 6	ш	Kohert Hel	me			Mes	inie Co	rulda	240
5 should be detached notified at once.	TO B	190. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street		I Route Number, City or To	wn, State, Zip Co	de)
	٦	Mabel B. the	mas	1117	- Oaka	ale DR	Huatts	ville,	md. 20782
by the funeral director, page moval, Ilical examiner must be	1 1	20s. METHOD OF DISPOSITION 1 XBurlel 2 Cremetion 3 Ren		b. PLACE AND DATE		lame of	DATE 20c. L	OCATION — City	or Town, State
lirector, p		4 Donation 5 Other (Specify)		Elenu		emeter	a 4/12 4/8	ashin	aton De
e funeral die L' examiner		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE 2		22. NAME	AND ADDRESS OF	ENCILITY THORTO	gomany	Brokas FIA.
e fur		Lactorne on	Montgom	ne #81	19 419-	Kennon	1. St. Mi	Lulad	Dancel
d in by the or removal medical		23. PART I. Enter the diseases, or	complications that cause	ed Ma death. Do	not enter tha m	ode of dying, su	oh as cardiac or res	piratory arrest	Approximata
D o E		ahock, or heart fellure. IMMEDIATE CAUSE (Final	List only one ceuse on	aach line.					Intarval Betwee
		disease or condition	AFDI	RAM	0 7	DNE	UMONI	A	1 5
		reaulting in death)		A CONSEQUENCE	OF):	-			
nd cor burial,	Z	unit controls	BR	AIR	2015	m s	SUROFE		2 Mang
3 0 5	E E	Sequentially list conditiona, if any, leeding to immediate	DUE TO (OR AS	A CONSEQUENCE	OFI:				000
	2	CAUSE (Disease or injury	· HTHE			VIE ,	HEART	brei	TE Yearn
of See	빝	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):				
the attend Mental Hy Ijury, or	CERTIFICATION		d						
		PART II. Other eignificent condition	ne contributing to deeth	but not resulting	in the underlyi	ng ceuse given i		N AUTOPSY	24b. WERE AUTOPSY FINDING
ed by th and	EDICAL	BENAL	FAIC	URE			PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
en signed of Health	MEC		5EPS11					92.10	OF DEATH?
		DID TOBACCO USE O	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES NC			
OR ALLEMOING FIT STOCKER, FIRE LAW DIRECTOR: After this certificate has be hours after death with the State Dept, Item 28 is marked, or Item 23 (SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (C	Check only one)		
or It	l Si	1 TYES 2 NO	HOSPITAL:	Ipatient 3 DOA	OTHER: 4 Nursing No	me 5 🗆 Reeldence	8 Other (Specify)		
this cer with th	PHY	27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)			JURY AT	28d. DESCRIBE NOW	INJURY OCCUR	ED
fler this cleath with marked,	8	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO			
DR: A	8	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJUR building, atc. (Spe	IY — At home, term, scily)	street, tactory, off	ce	28t. LOCATION (Street City or Town, State	and Number or f	Rural Route Number,
DIRECTOR: After hours after death item 28 is mai									
AL DIRECTOR	COMPL		ICIAN: To the best of my know						
FUNERAL WITHIN 72 H	Š	2 MEDICAL EXAMIN	R: On the basis of examination	on end/or investigat	ion, in my opinion,	death occured at th	e time, dats and place, e	and due to the ce	Puse(s) and manner as stated,
THE FUNER filed within	ш	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NO	UMBER	29d. DATE SI	GNED (Month, Clay, Year)
2 C 2 Z	0 8	Indlata				1199	17)	> 0 c	4/07/95
1	-	30. NAME AND ADDRESS OF PERSON WE	~ ~ C1 . /	EATH (ITEM 27) (Typ	e, Print) A	6 #230	, Atkon	A DA	8 F
31		F 7 NA HUKU	R. 1610		10 6 11 1	F		mb	20914
	ı I	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGI	NATURE					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



MORE, MARYLAND 21215-0020	ge 6 may be retained by the hospital or attending physician.	frector, page 5 should be detached for use as the burial-transit permit. Pages 1,
BALTII	24 hours after death. Pa	y filled in by the funeral of tion, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND 21215-0020	PINAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 17 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

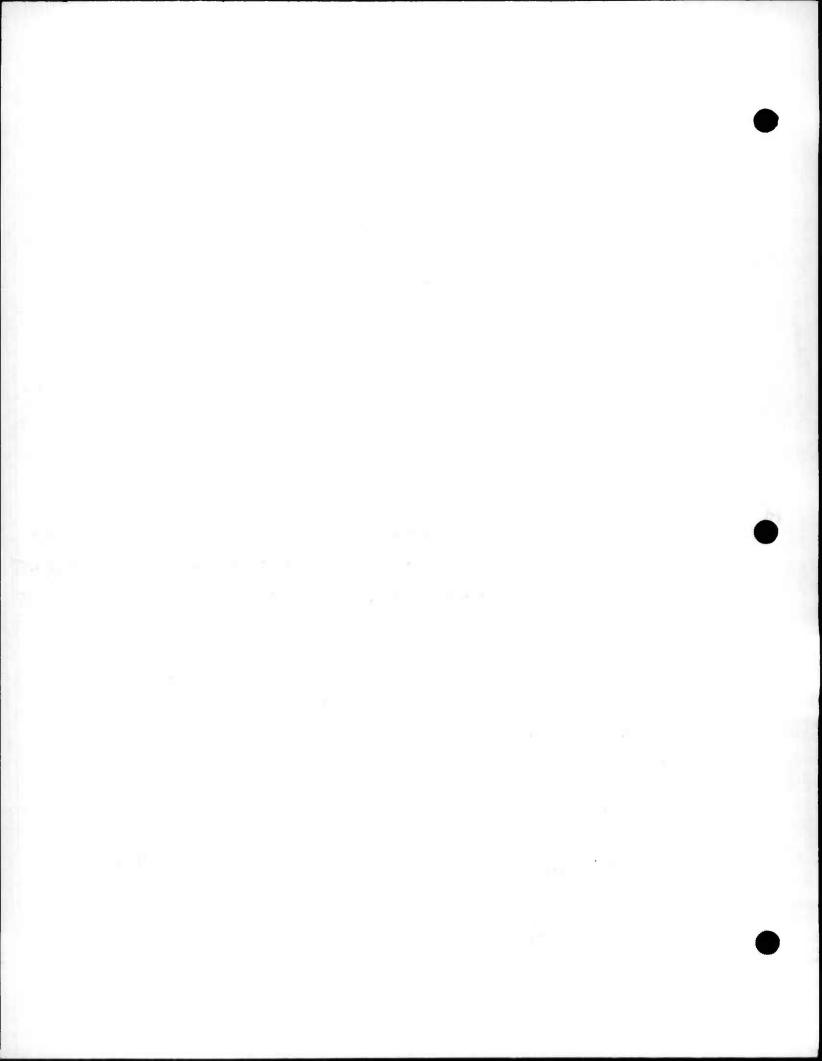
		1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL HYGIEN REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
		Marvin	A.	Penni	noton		Annil 20		5:20 a M
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	THPLACE (State or Foreign
-		217-10-5348	1 M 2 □ F	75 YRS.	MONTHS DAYS	HOURS MIN.		1020 Wa	st Virginia
3 should		9a. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH
2,3	DIRECTOR	Frostburg Hospit	al		Fr	ostburg		47.7	eganv
	딚	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		140.00				64.7	
Page	E E			10c. CI	TY, TOWN OR LOCA				10d, INSIDE CITY LIMITS?
permit. Pages 1,		Maryland Al	legany			ostburg			1 X YES 2 NO
2.	FUNERAL				10	H. ZIP CODE		· ·	WHAT COUNTRY?
-0020 ing physician. the burial-transit	N N	229 W. First Stre	12. WAS DECEDENT EVER	MILE ADMIN		21532			S.A.
)20 ohysic		1 Never Married 2 Married	FORCES? 1 X YES	2 NO	If yes, sp	pecify Cuban, Maxica	NIC ORIGIN? (Specify Yes an, Puarto Rican, etc.)	or No- 14. RAC	CE — American Indian, ck, White, etc.
The First	В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 TYES	S 2 NO Specif	fy:	Spe	White
YLAND 21215-0020 by the hospital or attending physician, be detached for use as the burial-trai	ED	15. DECEDENT'S EOUC	ATION	16a, DECEDENT'S	USUAL OCCUPATI	ION	16b. KIND OF BUS	SINESS/INDUSTRY	MILLOG
21.2 If or a	<u> </u>	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during me se retired.)	ost of working			
hed in	필	12	0	Mair	tenance		Tire M	lanufacti	ring
YLAND S by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		
Z 2 2 7	ш	Payden B. Penni	ngton			Viola E	. Lewis		
MARN e retained the 5 should notified	8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Town	n, State, Zip Code)	
De ret	유	Mildred Penningt	on	229 V	V. First	Street F	rostburg,	Maryland	1 21532
ALTIMORE, death. Page 6 may be threat director, page .		20a METHOD OF DISPOSITION 1 2 Burlai 2 Cremation 3 Remo	20	b. PLACE AND DATE	OF DISPOSITION (N.			CATION — City or T	
AOR pe 6 may rector, p		4 Donation 5 Other (Specify)	781 Irom State ce	metery, crematory or c Eckhart (emetery	April 2	22. 95 Eck	hart, Ma	ervland
TIN Ral di		21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE			ND ADDRESS OF FA		Funeral	
BALTIMORE, MARYLAND 21215-0020 ler death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial val.		> Tohu K.	Kurit	_	57 Fr	rost Aver	ue Frostbu		
hours after of in by the or removal.		23. PART I. Enter the diseases, or co	emplications that cause	ed the death. Do					Approximate
within 24 habitetely fille cremation, vent, the		ahock, or heart feilure. L IMMEDIATE CAUSE (Fine) disease or condition resulting in desth)	ist only one ceuse on	each line.			e to fly	2	Interval Between Onset and Death
68 and cand cand cand cand cand cand cand c	NO O	Sequentially list conditions, b		A CONSEQUENCE O		1000			0
a cian	RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	332 10 (0.1. 1.0	A GONGE GOETIGE O	•).				
certificate ding physical sygiene pri	트	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):				
A - E - E	E	resulting in deeth) LAST	5.						
the death by the attended Mental H	၂ပ၂	PART II. Other significant conditions	and the state of t	Con and a constant	L. M. C. C. C. C. C.	.7.	- T		
ORD; that the ed by the th and M	CAL	ASTISTORI	11	Dan A	La bruch	g cause given in	Pert 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
w requires that been signed I pt. of Health a shows any	MEDI	1 20 1 62 Cl	420 1-	will Co	- June	and,	1 TES 2	100	OF DEATH?
RECC requires to been signer t, of Health shows a		Col greative	man p	asun		ALD			1 TYES 2 NO
	Z	DID TOBACCO USE CONTR	BUTE TO CAUSE O		ES M NO [UNCERTAIL	N 🗆 📗		
一年 等等 量	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DAO	HOSPITAL:	26. PLACE OF OEA	OTHER:	ne 5 🗆 Residence	8 Other (Specify)		
1 0 5 5 °	主	27. MANNER OF DEATH	28s. DATE OF INJURY	26b. Till	E OF 28c. IN.	JURY AT	28d. DESCRIBE HOW IP	NJURY OCCUREO	
NG PHYS fler this c eath with	ВУ Б	1 Naturel 5 Pending	(Month, Day, Year)	IN.		ORK? YES 2 NO			
O O O O	0 8	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJUR	Y — At home, farm,	atreet, factory, offic	:0	28f. LOCATION (Street a	and Number or Rural	Route Number,
= = 5 ~ ~	ш	4 Homicide determined	building, atc. (Spe	ecny)			City or Town, State)		
OR OR DIRE	Ä	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	eledge death occurr	ad at the time date	and place and due	40.45	Wessells?	
로 크 오 누	COMPLET		On the beals of assistant						(a) and manner as stated
FUN WITH		250 AND TITLE OF CHITIEFER		1					
TO THE HOSPIT TO THE FUNERA DE filed within 7	H	(Mangay	mass	mo		1) 24C	95-1	. //-	(Month, Day, Year)
668₹	임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) /5	Print)	1	,,,	Lipli	100,70
G	1	Chang H. Oh, M.D.;	48 Tarn Ter	rrace, Su	ite 204:	Frostb	ourg, Md. 2	1532	
4		APR 2 1 1995	32. REGISTRAR'S SIGI	- Karlall					

A SERVICE OF THE SERV na giá. a

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MICHAEL PERRIN 1995 April 15. 10:25 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. HOURS 1 X M 2 - F 220-38-0446 25. May Pennsylvania hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Hospita Memorial Cumberland Allegany RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Pennsylvania Bedford ArTemas 1 - YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? HC-13 BOX /3 4514 7211 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) **BALTIMORE, MARYLAND 21215-0020** 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried В 1 TYES 2 D NO Specify: 3 R Widowed 4 Divorced White 15. DECEDENT'S EDUCATION

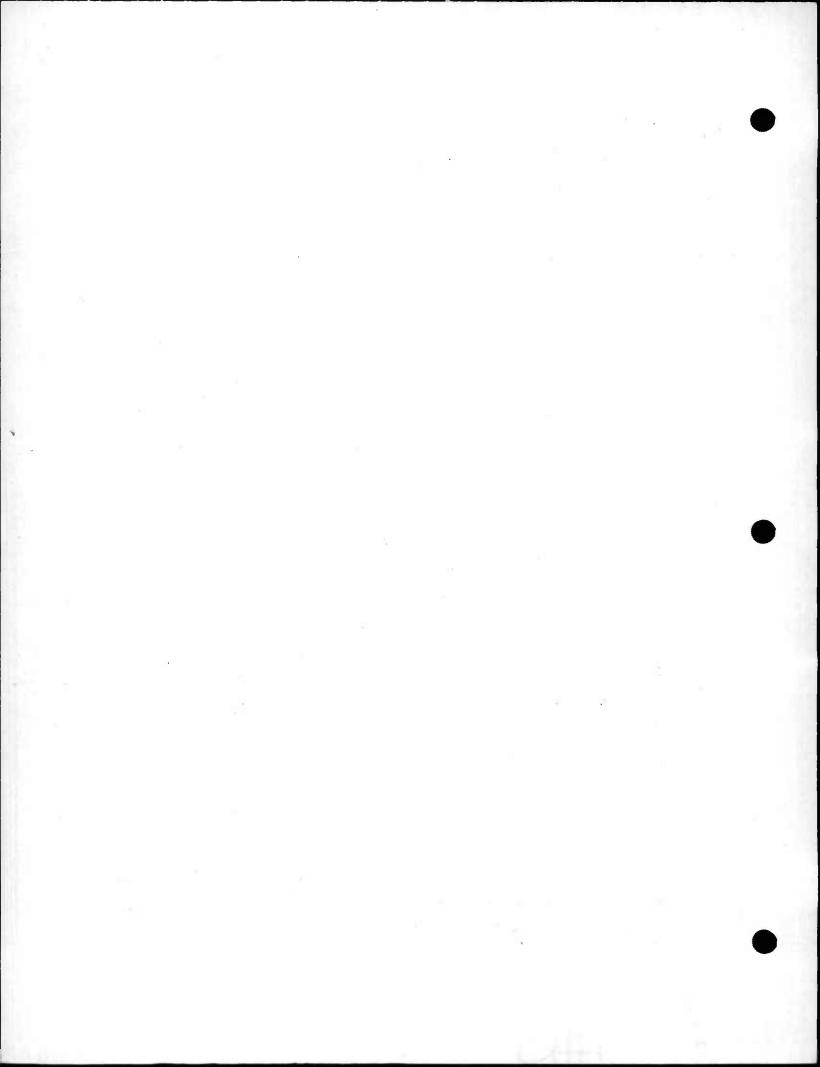
This highest grade completed) COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Farmer Farming 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme, hor 105 Perriw notified at BE Rose Kennand 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 charles M. HCR-13 Artomos, RONNG. Pe 20e. METHOD OF DISPOSITION
1 B Burlel 2 Cremation 3 Re
4 Donation 5 Other (Specify) Pank 1997 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Cumberland, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ernat Leasure-Stein, Inc. 230 Baltimore Avenue a. n by the I Cumberland, Md. 21502 other traumatic event, the medical filled in by ti Del 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory arrest, Approximata shock, or heart fellure. List only one ceuse on each line Interval Bety cremation, or IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) OKGESTIVE the attending physician and completely in Mental Hygiene prior to burial, crematic DAYS DIVISION OF VITAL RECORDS, P.O. BOX 68760 requires that the death certificate be executed with QUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSECU if any, leading to immediate cause. Enter UNDERLYING ORANGET CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST been signed by the PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TYES 2 TO NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 12 UNCERTAIN 1 THE HOSPITAL OR ATTENDING PHYSICIAN: The law THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) Tem HOSPITAL:
1 Pinpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 P NO 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural В 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28 is 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Steta) 6 Could not be COMPLETED 4 Homicide determined TO THE HOSPITAL OR ATT

TO THE FUNERAL DIRECTE
DE filed within 72 hours at
IMPORTANT: If item 28 29e. CERTIFIER To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ea stated. (Check only one) of examination and/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND L 29d. DATE SIONED (Month, Day, Year) BE 29c. LICENSE NUMBER D 16041 2 30. NAME AND ADDS S OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6 Williams. Memorial Hospital Medical Bldg., Cumberland, MD 21502 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE



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		1 - STATE REGISTRAR	3	STATE OF N	ARYL	AND / DEP/	RTMENT	OF H	EALTH	AND M		YGIEN			
		1. DECEDENT'S NAME (First, Middle	, Last)								2. DATE OF I	DEATH		3	. TIME OF DEATH
		Lynda Sue	Prop	st							April			YEAR	4:48AM M
		4. SOCIAL SECURITY NUMBER		SEX	6. AGE	(In yrs. last birtnde	MONTHS	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF E (Month, De	HRTN y, Year)		Country)	ACE (State or Foreign
P		219-78-0690 9a. FACILITY NAME (If not institution		□ M 2 💢 F	36	YRS					Jul 15	, 19			<u>1D</u>
3 sho	œ	SACRED HEART						BERL		ON OF DEA	TN		9c. COUNT	Y OF DEA	
1, 2,	5	RESIDENCE OF DECEDE	NŤ	TAL	_								1	JO2 11.4.2	
Pages	DIRECTOR		YTHUO				HTY, TOWN		ION					4.0	Od. INSIDE CITY LIMITS?
ij.		MD A	llega	ıny		Ci	mber.	_	. ZIP COD				I all amount		YES 2 NO
physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	218 Columbia	Stree	t Apt					1502	_			USA	EN OF WH	AT COUNTRY?
Sician.	N D	11. MARITAL STATUS	12	. WAS DECEDEN FORCES? 1	T EVER II	N U.S. ARMED		WAS DEC	ENDENT C	OF HISPANIC	C ORIGIN? (S		or No- 1	4. RACE -	- American Indian,
g phy	BY F	1 Never Married 2 X Marrie 3 Widowed 4 Divorced	1	IF YES, GIVE W	AR OR D	2 NO ATES		If yes, spen	2X NO	in, Maxican, Specify:	Puarto Ricar	t, atc.)		Specify;	White, atc.
or attending physician ir use as the burial-tra		15. DECEDENT	'S EDUCATI	ON		16a. DECEDENT	"e Hellal O	CCLIBATIO	NA		det VIII	0.05.00	SINESS/INDU		nite
or at	E	(Specify only higher Elementary/Secondary (0-12)	t grade com		-1	(Give kind life. Do NO	of work done use retired.)	during mo	st of workin	ng	10D, KIN	D OF BU	SINESS/INDU	SIHT	
ospital	COMPLETED	12			1	Secre	tary				Sa	acre	d Hear	rt Ho	spital
retained by the hospital 5 should be detached to totilled at once.	8	17. FATNER'S NAME (First, Middle, L	nst)								E (First, Middl	1	Surname)		
ed by	H	Leo F. Robi		e		Territoria de la constantina della constantina d			<u> </u>		P. R				
retained by the hospital or attending 5 should be detached for use as the notified at once.	욘	Harold J. Pro										-	n, State, Zip C	,	D 21502
		20g. METNOD OF DISPOSITION 1X Burlel 2 Cremetton 3			200	PLACE AND DA				L Api	DATE		cation - c	_ <u></u>	
e 6 mar rector, p		1X Buriel 2 Cremetion 3 4 Donetion 5 Other (Specif	Removal	from State	cen M	netery, crematory of t. Tabo	r other plece)	eter	V		04/12		dtown,		, 51410
death. Page funeral dire I. examiner n		21. SIGNATURE OF FUNERAL SERV	ICE LICENS	SEE		. //	22.	NAME AN	D ADDRE	SS OF FACI					
		(James	7 (XICa	10					. Fun∈ d, MD	eral H				
ely filled in nation, or re		23. PART I. Enter the disease shock, or heart for iMMEBIATE CAUSE (Finel disease or condition resulting in death)	illure. Liat	Dnly Dne cau	ise on e	d tha daeth. Diech lina.		the mo	da of dy	ing, such	as cardiac	or reap	iratory arre	st,	Approximate interval Between Onset and Deeth 2 hours
and com burial,	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	6	Dissemi DUE TO	inat (OR AS A	ed Intra	avasci of):			gulo _i s	athy				2 hours
he death certificate be e the attending physician Mental Hygiene prior to njury, or other traun	2	CAUSE (Disease or injury	c	Post of	era:	tive sa	lpinge	ecto	ny						3 days
the death certificate of the attending physical of Mental Hygiene pri Injury, or other to	E	thet initiated eventa resulting in desth) LAST			•	eft ect		regi	nanc	У					3 days
death e atte fental		DART II Other significant and	0.												1
that the by the and the and I	EDICAL	PART II. Other algorificent con	iditione ci	ontributing to	deeth b	out not recultin	g in the ur	iderlying	g ceuse (given in P		PERFOR	V	C	/ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?
w requires been sign of, of Heal	 M	DID TOBACCO US	SE COI	NTRIBUTE	TO	CAUSE O	F DEAT	H YE	S 🗆	NO	Eri I			'	YES 2 NO
N: The law icate has bostate Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDI EXAMINER?	CAL					26. PL		EATH (Chec	k only one)				
ician: The ertificate the State or Item	YSI	YES 2 NO	3	SPITAL:	ER/Outp	patient 3 🗆 DOA	4 Nur		e 5 □ Re	esidence 6	Other (Sp	ecify)			
his c with with	ву Рн	27. MANNER OF DEATN 1 Netural 5 Pendin 2 Accident Investig		28a. DATE OF (Month, D	ay, Year)	:/	IME OF NJURY M	1 🗆 1	RK? res 2 [28d. DESCRII	BE NOW I	NJURY OCCU	RED	
L DR ATTENDING F DIRECTOR: After the hours after death item 28 is mar	ETED	3 Suicide 8 Could 4 Nomicide determ		28e. PLACE O building,	F INJURY etc. (Spec	(— At home, terr	n, street, fact	ory, office	•	:	261. LOCATIO City or To	N (Street i wn, State)	and Number o	Rural Rou	ite Number,
4 7 C 2	COMPL					rladge, death occ in and/or investig									ind manner ea stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE (296. SIZHATUHE AND TULE OF CE	PITUPLER						29c. LICI	ENSE NUMB	BER		29d. DATE	SIGNED (A	fonth, Day, Year)
P P 3 ₹	10	AND ADDRESS OF PERS	ON WHO ~	OMBI ETER ACT	I	Doty Med	Ex		D (9157			Apr	i1 1	1.1995
$ \sqrt{1} $		Paul Snow, M. D.				, , , , ,		>							
/		31. DATE FILED (Month, Day, Year)		SEGISTRA			21002						-		
_		ADD 1 9	E M III	TABLE .	S. S. Shanne	Man Man Contraction									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. In the second physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.								
	. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH			
	HARRY	WALTER		PETERS		APRIL 8,	1995 "	10:30 A ^M	
	4. SOCIAL SECURITY NUMBER 351-16-4234		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 7 1925	6. 6	BIRTHPLACE (State or Foreign Country)	
		1 ⊠ M 2 □ F 69	YRS.	- 11	1100			ILL.	
Œ	98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH SACRED HEART HOSPITAL 90. COUNTY OF DEATH ALLEGANY							1.1.1.1	
210	RESIDENCE OF DECEDENT								
DIRECTOR	10e. STATE 10b. COUNTY			TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
	MARYLAND ALLEGANY LAVALE 100. STREET AND NUMBER							1 YES 2 NO	
FUNERAL	13802 BRIARWOOD D		21502			10g. CITIZEN OF WHAT COUNTRY?			
N N	11. MARITAL STATUS	12 WAS DECEDENT SYSTEM	U.S. ARMED			IIC ORIGIN? (Specify Yea		RACE — American Indian.	
B	1 Never Married 2 XXMarried 3 Wildowed 4 Divorced	FORCES? XX YES IF YES, GIVE WAR OR DA US NAVY WW]	ATES	If yes, sp		n, Puerto Ricen, atc.)		Black, White, stc. Specify: WHITE	
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPATION dork done during mo	ON st of working	16b, KIND OF BUS	INESS/INDUST	RY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)					
Š	1.2 17. FATHER'S NAME (First, Middle, Last)		CSX RAII	ROAD WE	LDING DI				
	WALTER PETERS			18. MOTHER'S NAME (First, Middle, Melden MINNIE GANZER					
BE	19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Co						, Stete, Zip Cod	fe)	
임	MARJORIE PETERS								
	20a, METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Burial 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Ram	oval from State 20b.	D. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State RFD APRIL 11 1995 FLINTSTONE MD.						
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		CKY GAP V					FLINTSTONE MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdishock, or heart feilure. List only one cause on each line.									
	IMMEDIATE CAUSE (Fins)						Interval Between Onset and Death		
	disease or condition resulting in death)	Prefa	awand sersis					2 dan	
		DUE TO (OR AS A	A CONSEQUENCE OF):						
ERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Diseas							3 Olars	
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	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	: 3	,			3	
CER	resulting in deeth) LAST a government of the second of the							13 clays	
A	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY FINDINGS								
	Service Cutivity Services Performed? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Performed?								
MEDIC	- Mys found of m for estion								
N N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN:	EXAMINER? HOSPITAL: OTHER:								
Ë	27. MANNER OF DEATH	1 ☐ Impetient 2 ☐ ER/Output 28e. DATE OF INJURY	28b. TIME		5 Realdenca	6 Other (Specify) 28d. DESCRIBE HOW IN.	JURY OCCURE	50	
BY P	1 Natural 5 Pending	(Month, Day, Year)	INJU	M 1 1	RK?	200. DEGOTIOE HOW IN	OUT OCCURE		
- 11	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Speci	RY — At home, farm, street, factory, office 28f. LOCATION (Street				and Number or Rural Route Number,		
COMPLEIED	4 Homicide determined City or Town, State)								
7	29a. CERTIFIER (Check only one) One								
5	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.								
								GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) 915 SCION DV. C. C. C. C. C. C. C. C. C. C. C. C. C.								
	eleu I S K	95 year 135	est handall						

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notitied at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAL HYGIEN	_	0 10009
	1. DECEDENT'S NAME (First, Middle, Last)	-	<u> </u>	DATE OF	DEATH	2. DATE OF DEATH	,. 	3. TIME OF DEATH
	ROBERT MC			1 190	75 ~ 7:00 AM			
				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		3. BIRTHPLACE (State or Foreign
	377-20-8061	× M 2 □ F 69	YRS.	NONTHS DAYS	HOURS MIN.	(Month, Day, Year) January		6 Michigan
	9s. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF D			Y OF DEATH
۳,	17710 Indian Hea	ad Hwv.		Acco	keek			CE GEORGES
DIRECTOR	RESIDENCE OF DECEDENT			11000	neen .		1.10//	00 0001000 5
2	10e. STATE 10b. COUNTY			TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
		e George	Acc	cokeek			1 TES 2 NO	
₹ I	10e. STREET AND NUMBER				. ZIP CODE			EN OF WHAT COUNTRY?
FUNERAL	17710 Indian Hea				20607			S.A.
	11. MARITAL STATUS 1 Never Merried 2 Merried	WAS DECEDENT EVER IN FORCES? A PYES	U.S. ARMED 2 NO	13. WAS DEC	ENDENT OF HISPA ecify Cuban, Mexic	NIC ORIGIN? (Specify Ye en, Puerto Ricen, stc.)	e or No—	4. RACE — American Indien, Black, While, etc.
BY	3 Widowed 4 Divorced	1944 - 1	946	1 TYES	2.XIXIO Specif	en, Puerto Ricen, stc.) fy:	-	Specify:
	15. DECEDENT'S EDUCATION	ON	16e. DECEDENT'S U	SUAL OCCUPATI	ON	18b. KIND OF BU	SINESS/INDI	White
	(Specify only highest grade comp	ollege (1-4 or 5+)	(Give kind of wo	rk done during me	st of working		01112007111000	
립	12	1	Airplan	ne Mec	hanic	Air	lines	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maider	Surname)	
BE C	James Quinn				Kath1	een D	oyle	
0 0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street	and Number or Rural	Route Number, City or Tov	vn, State, Zip C	ode)
۱۶	Susana Quinn		P.O.	Box 1	56, Bry	ans Road	, Md.	20616
	20a METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Removal	20b. F						ty or Town, State
l	4 Donation 5 Other (Specify)	Mar	PLACE AND DATE OF tery, cremetory or other yland	Vetera	ns Cem.	Che	ltenh	am, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS	EE /		22. NAME A	O AOORESS OF FA	CILITY		
	* West And	lean	M00668			ineral Ho		
	23. PART I. Entar the diseases, or comp			t enter the mo	de of dving euc	the cardiac or reen	u., 1	ndian Head, Mo
	anock, or heart failure. List	only one cause on aac	ch lina.	t order the me	da oi dyilig, suc	ir as caldiac or rasp	matory arres	interval Batween
	immediate Cause final disease or condition resulting in death) a. Acute Myocardial Infarction minul							
ŀ	resulting in death) a	DUE TO (OR AS A	CONSTOURNCE OF	८ वास	infarc		minico	
-								1,,000
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. CORONARY Heart Disease DUE TO (OR AS A CONSEQUENCE OF):							geans
8	cause. Entar UNDERLYING CAUSE (Disease or injury that Initiated avants CAUSE (Disease or injury that Initiated avants CAUSE (DISEASE OF): Year							
프	that initiated avants	DUE TO (OR AS A)	CONSEQUENCE OF):					Julia
ᇤ	reaulting in death) LAST							
	PART II. Other aignificant conditions co	ontributing to death bu	t not resulting in	the underlyin	a course shown in	Part i. 24a, WAS AN	LAUTODON	
CAL		The state of the s	t not readiting in	the underlyin	J cauda given in	PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 YES :	2 XNO	OF DEATH?
Σ	DID TOP ACCOUNTS CONTRIBUTE	LITE TO CALLES OF	DE 4711 1/70					1 TES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTION OF THE PROPERTY O		DEATH YES	_	UNCERTAI			
힐	EXAMINER?	OSPITAL:		OTHER:	14			
¥	1 VES 2 NO 1	Inpetient 2 ER/Outpet	26b. TIME		e 5 KRseldence	8 Other (Specify)		
	1 Naturel 5 Pending	(Month, Day, Year)	INJU	M 1	RK?	28d. DESCRIBE HOW	INJURY OCCUI	RED
B	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF INJURY -	- At home form etc			281. LOCATION (Street	and Months	Out Date Name
	4 Homicide determined	building, etc. (Specify	()	rei, rectory, drine		City or Town, Steta,	and Number or	rurai Moule Number,
COMPLETED	29e. CERTIFIER							
MP	(Check only	To the best of my knowled	dge, death occurred	at the time, data	end place, end due	to the ceuse(s) and me	nner ee stated.	
8		Time basis of examination	and/or investigation,	in my opinion, d	eath occured at the	time, dats end placs, er	nd dus to the o	ceuse(e) end menner ee stated.
88	29b. SIGNATURE AND TITLE OF CERTIFIER		SIGNED (Month, Day, Year)					
6	Seryen MI) (isme j			D259	25	17	ne 21, 1995
	J. BERGER MD #	MPLETED CAUSE OF OEAT	TH (ITEM 27) (Type, P	rint)	0	·77.		- C://
	A DATE EN ED CALLED AT A	OMPLETED CAUSE OF OEAT 205 7720 32. REDISTRAR'S SIGNAT	WISCOM	ISIN A	ve B	ernosda,	md	20814
	31. OATE FILED (Month, Day, Year) ADD 9 C 1005	32. REGISTRAR'S SIGNAT	TURE PLANT				_	
	APR 2 6 1995	June animari	M. P. Brokeri					

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BALTIMORE, MARYLAND 21215-	ther death Pane 6 may be retained
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	PHY
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing mountained by the floribitation or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be followed by the funeral physician processes to the burial-transit permit. Pages 1, 2, 3 should be followed by the funeral physician processes the burial-transit permit. Pages 1, 2, 3 should be followed by the physician.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Las	asi) 2. DATE OF DEATH 3.								TIME OF DEA	TH	
	JUNE EL	AINE	INE RICE						April 7, 1995 YEAR 9:30			Ам
1	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last		IF UNDER 1 YEA		7. DATE OF	ATE OF BIRTH 8. BIRTHPI			ACE (State or F	oreign
	554-26-3154	1 □ M 2 😿 F	78	YRS.	MONTHS DAY	S HOURS MIN.		3,191		ali:	fornia	
	9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOW	N OR LOCATION OF I	DEATH		9c. COUNTY	OF DEAT	гн	
5	221 Glen Ave.				Sa	alisbury			Wi	comi	co	
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	ITY		10c. CITY.	TOWN OR LO	CATION				1 10	id. INSIDE CIT	v
DIRECTOR	Maryland Wi	comico			Salisl						LIMITS?	
	10e. STREET AND NUMBER		-			10f. ZIP CODE	10g. CITIZEN OF WI					110
EB	221 Glen Ave.					21801			US	A		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARI	MED	13. WAS	ECENDENT OF HISPA	NIC ORIGIN?	Specify Yes	or No- 14.	RACE -	American Ind	lan,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA		V		specify Cuban, Maxic ES 2 NO Spec		an, atc.)		Specify:	fhite, etc.	
	15. DECEDENT'S ED	I .	44 . 95							Whit	e	
III.	(Specify only highest gra-	de completed)	(Gr	ve kind of wo Do NOT use	SUAL OCCUP. ork done during retired.)	most of working	16b. K	IND OF BUSI	NESS/INDUST	RY		
P	Elementary/Secondary (0-12)	College (1-4 or 5 +)	-		maker							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			HOME	- Indirect	18. MOTHER'S N	AME (First, Mic	Idle Maiden S	(urname)			
	John Henry t	ingley				Cora	_	belle	Bent	on		
BE	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS (Stre	et and Number or Rura	Route Number	City or Town,	State, Zip God	ie)		
TO BE COM	Louis Rice			221 G	len Av	re., Salis	sbury,	MD 2	1801			
12	20a. METHOD OF DISPOSITION 1 (X Burlel 2 Cremetion 3 Re	moval from State			DISPOSITION	(Name of	DATE	20c. LOC.	ATION — City	or Town,	Stata	
	Bethel Methodist Cemetery 4/12 Lewes, Delaware											
TSPILLIAN TO THE TOTAL THE TOTAL TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO TH	21. SIGNATURE OF FUNESIAL SERVICE (JCENSEE /	7			AND ADDRESS OF F	ness of Facility Ly Funeral Home					
	1 PM	Kellou	ren			l Snow Hi			ishurv	M	D 2180	1
	23. PARTA. Enter the diseases, or	complications that	caused the de-	eth. Do no	t enter the	mode of dyling, au-	ch aa cerdle	c or reepire	atory erreat,	,	Approxim	ate
מבשור, ווופ ווופחולפו									Intervsi E Onaet an			
5	disease or condition resulting in deeth)								1 per	THE STATE OF		
	DUE TO (OR AS A CONSEQUENCE OF):									1	ŧ	
ATION	Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF):									1		
AT	If eny, leading to immediate ceuse. Enter UNDERLYING	552.10(0	M AS A CONSEC	DENCE OF	•							
F	CAUSE (Disease or Injury that Initieted events	cDUE TO (C	R AS A CONSEO	UENCE OF)								
CERTIFICATION	resulting in death) LAST	d										
	PART II. Other aignificent condition	one contributing to d	anth hut ant a		45							
N N	PART II. Other alginicent condition	Mile Contributing to a	eeth but not re	euiting in	the underly	ing couse given in	Part I. 2	En. WAS AN A PERFORM		AW	RE AUTOPSY F AILABLE PRIOR	TO
							— l¹	YES 2	NO		MPLETION OF DEATH?	CAUSE
Σ	DID TOBACCO USE CON	TDIDLITE TO CAL	CE OF DEAT	TIL VEC	- D NO	C) UNICEDIA			i	1 [YES 2	MO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAU		_	(Check only o		иПТ					
	EXAMINER?	HOSPITAL:			OTHER:							
H	27. MANNER OF DEATH	28a. DATE OF IN	IJURY	28b. TIME	OF 28c.	ome 5 TResidence		-	JURY OCCURE	D		
	1 Natural 5 Pending	(Month, Day,	Year)	INJU		WORK? YES 2 NO	100000000					
	2 Accident Investigation 3 Suicide 8 Could not be	28a, PLACE OF	INJURY — At hon	na, form, atr	eet, factory, o	fica			d Number or R	ural Route	Number,	
TE	4 Homicide determined	bonong, at	c. (Specify)				City or	Town, State)				
PLE	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the beat of m	y knowledga, daa	th occurred	at the time, d	ets and place, and du	to the cause	(s) and mann	er as stated.			
COMPLETED		NER: On the beels of exam								use(e) en	d manner ee s	stated.
									29d, DATE SIG	NED (Mc	onth, Day, Year)	
- 1	Benjamin	H K	lege	1/		D 30-	1 43		D 41	12	195	-
2		THO COMPLETED CAUSE	V .						-/	1	10-	
		eyer, 40	3 Qui	NCY.	st. , 8	Alisbury	, Md.	21803	4			
,	APR 14 1995	32 REGISTRAR	S SIGNATURE	0 10		1		0 11				
لسا	71 1 1 4 199) Have we	WASH NOW	(ALE)		<u> </u>						

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a front death. Page 6 may be retained by the retending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MAI		PARTMENT O		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Milton			Russell		April 18	, 1995 YEAR	2150 M	
			AGE (In yrs. last birt	hday) IF UNDER 1 YE MONTHS DA	The state of the s	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign	
	219-16-0404	1XXM 2 F	71 Y	RS.	TS HOURS MIN.	Aug. 18,1	923 Ma	ryland	
(C)	9a. FACILITY NAME (If not institution, give stre			9b. CITY, TO	VN OR LOCATION OF I	DEATH	9c. COUNTY OF	DEATH	
5	Calvert Memorial	Hospital		Princ	e Frederi	ck	Calv	ert	
DIRECTOR	10a. STATE 10b. COUNTY		10	e. CITY, TOWN OR L	CATION			10d. INSIDE CITY LIMITS?	
		vert		Prince H	rederick			1 TES 2 NO	
PAL	100. STREET AND NUMBER 315 Sixes Road				101. ZIP CODE			WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV			20678		USA		
	1 Never Merried 2 X Merried	FORCES? 1	YES 2 X NO	If ye	, specify Cuben, Maxie	ANIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	814	CE — American Indian, ick, White, etc.	
BY	3 Widowed 4 Divorced	IF 1E3, GIVE HAR	OR DATES	יי	YES 2 X NO Spec	lly:	Spi	octy: Black	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16e. DECEDE	ENT'S USUAL OCCU nd of work done durin VOT use retired.)	ATION a most of working	16b. KIND OF BU	SINESS/INDUSTRY		
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	1						
M	17. FATHER'S NAME (First, Middle, Last)		Truc	k Driver	[Freigl			
Ш	Isaac	Russe	11		Helen	AME (First, Middle, Maiden	_		
00	19a. INFORMANT'S NAME (Type/Print)		ILING AODRESS (St)		I Route Number, City or Tow	Stewa	rt		
2	Ella Louise Russell	L				e Fredericl		678	
	20a, METHOD OF DISPOSITION 1 ABuriel 2 Cremation 3 Remov	rai from State	20b. PLACE AND I	ATE OF DISPOSITIO	(Name of	DATE 20c. LO	CATION — City or	Town, State	
	4 Donation 5 Other (Specify)		Mt. Oli	ve UM Ch	urch Cem.	4/22/95 Pri	ince Fre	derick, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			E AND ADDRESS OF F	pewell	Funeral		
	Spencer	E Sen	rela	1451	Dares Be	ach Rd. Pri	ince Fre	derick, MD	
	23. PART I. Entar the diseases, or co shock, or heart fallure. Li	emplications that callat only one cause i	used the death. on each line.	Do not entar the	mode of dying, au	ch as cardiac or reap	iratory arrest,	Approximate interval Batween	
	IMMEDIATE CAUSE (Final disease Dr condition resulting in death) a. CONSESTIVE HEART FRILURE /YR								
	reaulting in death)	DUE TO COR	10 1 00110001101			14r			
	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
9									
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	DABE	765	MEUL	105				
E	that initiated events reautiting in death) LAST	DUE TO (OR	AS A CONSEQUEN	CE OF):					
CERTIFICATION	d.								
AL.	PART II. Other significant conditions	contributing to des	th but not reaui	ting in the under	ying cause given is	Part i. 24a. WAS AN		Ib. WERE AUTOPSY FINDINGS	
1 (5)						1 _ YES 2	meb!	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDI				•		/	4	1 TES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTRI	BUTE TO CAUS			NCERTAL	N 🗆			
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:					
H X	27. MANNER OF DEATH	1 Inpetient 2 ER			INJURY AT	6 Other (Specify) 26d. DESCRIBE HOW I	N KIRW OCCUPED		
	Natural 5 Pending Investigation	(Month, Day, Ye		INJURY	WORK?	260. DESCRIBE HOW I	NJOHY OCCURED		
0 87	3 Suitcide 6 Could not be	28e. PLACE OF IN. building, stc.	JURY — At home, for	erm, street, factory,	ffice	281. LOCATION (Street		l Route Number,	
TED	4 Homicide determined	banang, stc.	(Opecny)			City or Town, State)			
COMPLET	29a. CERTIFIER (Check only	AN: To the best of my I	late end place, end du	to the ceuse(s) end man	nner se stated.				
O.	one) 2 MEDICAL EXAMINER:				(e) end menner se stated.				
ш	296. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DATE SIGNE	ED (Month, Day, Year)	
TO B	Churt	nel			0296	57	D 4/19	9/95	
-	30. NAME AND ADDRESS OF PERSON WHO, Charles Judge,	D CAUSE O	F DEATH (ITEM 27)	(Type, Print)	Duin T		D 00070		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE		rrince Fi	rederick, M	ID 20678		
	APR 21 1995 Julia Davidson Randall								

C 3 5 N

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	E FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should	led within 72 hours after death with the State Dept. of Health and Mental Hygiene pnor to bunal, cremation, or removal.	Commence of the commence of th
	THE HOSE	THE FUNE	led within	STA STATE

31. DATE FILEO (Month, Day, Year)

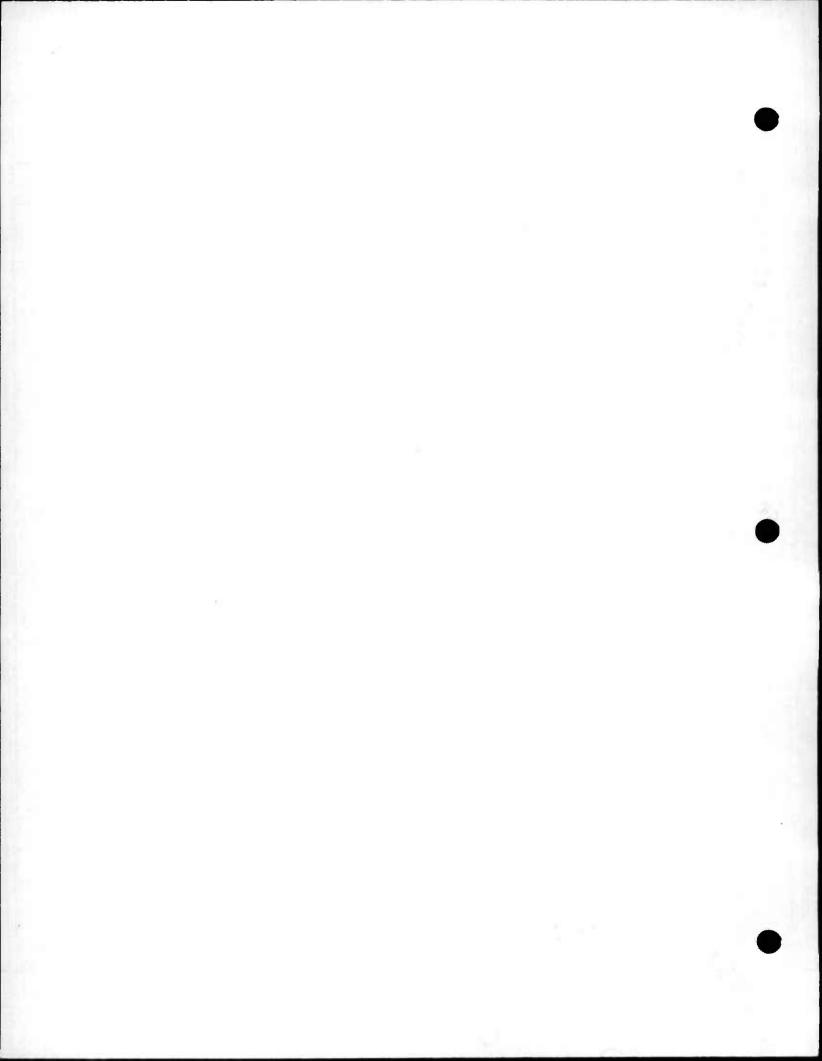
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32. REGISTRAR'S SIGNATURE Julia Davileon Randall

1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OEATH DAISY FAYE ROBINSON 1995 April 18 9:15 A.M. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) HOURS 1 🗌 M 2 ⋤ F 249-01-9201 MIN. 83 YRS. May 14 N.C. P 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 463 Tumbleweed Trail Lusby Calvert RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Solomons 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 1472 Solomons, Md. 20688 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yea, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Bleck, White, atc. 1 Never Merried 2 Married Specify: White BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grade Waitress Restaurant 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Jacob Clontz Virgie Hough BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara Phillips Same as 10e 2 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE tic Buriel 2 Cremation 3 Removal from State April 21, 1995 Suitland, Md. 21. SIGNATURE OF FUNERAL GERVICE LICENSEE \$2. NAME AND ADDRESS OF FACILITY Raymond Funeral Home, P.A. 10684 So. Md. Blvd. Dunkirk. Md. 20754 medicai 23. PARY I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line Interval Batween IMMEDIATE CAUSE (Final Onset and Death E e disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): occled CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other algnificant conditions contributing to death that not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE to- (4 1 TYES 3 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2-NO 1 - Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 3 ☐ Rasidence 8 ☐ Other (Specify) 27. MANNER OF OEATH 26a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. OESCRIBE HOW INJURY OCCURED Netural 2 Accident 5 Pending M В 1 YES 2 NO Investigation 28a. PLACE OF INJURY — At home, ferm, street, lectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 0 6 Could not be 4 Homicide П 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIES 8 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 890 2 2 3 X 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jonathon Lowenthal, M.D. 120 Hospital Dr., Prince Frederick, Md. 20678



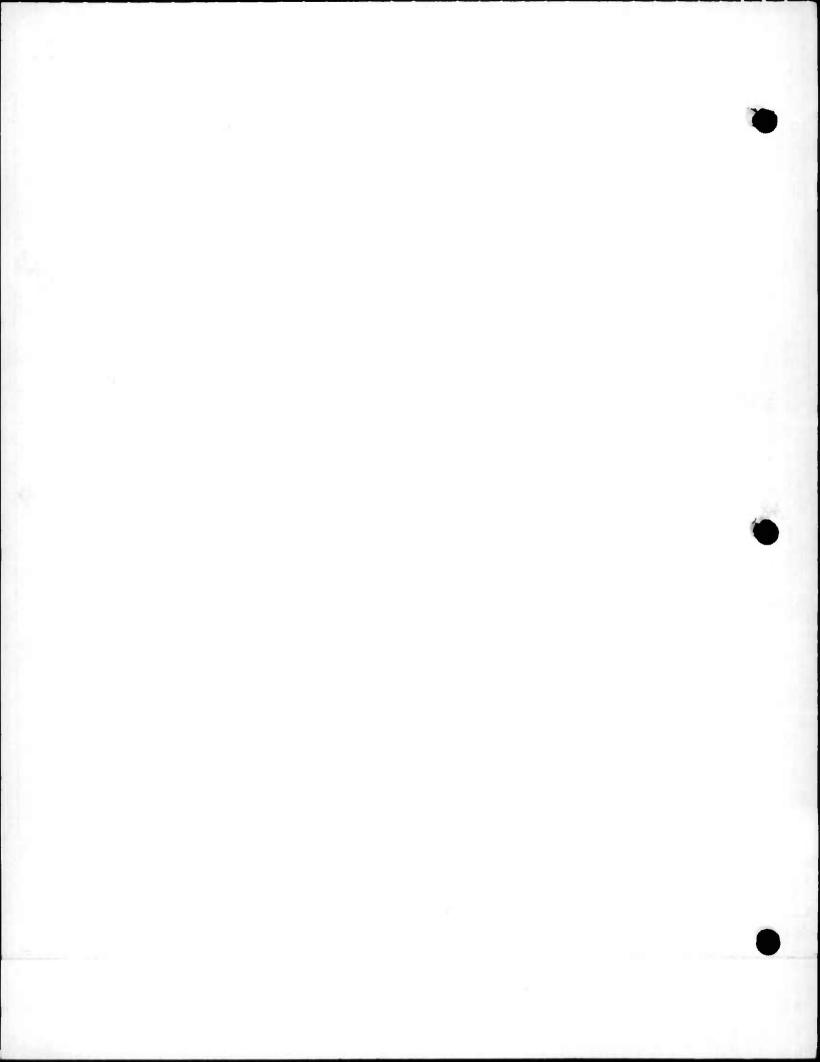
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ITTER ANB 14:10 APRIL 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday, IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign 1 M 2 XF 578-82-0256 7 Aug Washington DC Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY С. D. N/A Washington permit. 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. 812 Somerset Place N. W. 20011 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 Never Married 2 Married В Specify: 3 Widowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 166. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Realtors 5+ Mongomery Co. Assoc of Publications Specialist 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) to Martin Ritter 8 Vivian Lee notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Vivian Ritter Somerset Place N W Washington D. C. 20011 ě 20a. METHOD OF DISPOSITION

1 Seriel 2 Cremation 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must etery, cremetory or other plece) emorial Park Gardens Memorial 4-18 Battle Creek Michigan examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marshall's 4217 9th Funeral Home Inc Street, N. W. 22. NAME AND ADDRESS OF FACILITY 20011 Washington, DC medical 23. PART Lenter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Finel** Onset and Death the disease pr condition_ PULMONAR EMBOLLSM executed within resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, 9 signed by the attending physician and Health and Mental Hygiene prior to if any, leeding to immediate cause. Enter UNDERLYING 2 requires that the death certificate CAUSE (Disease Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? OBESIT any 1 TYES 2 THO shows a 1 YES 2 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DO NO CERTAIN D PHYSICIAN: certificate has be DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 14 YES 2 NO atlent 2 -ER/Outp atlent 3 🗆 DOA 4 - Nursing Home 5 - Realdence 6 - Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF this c. 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED marked, 1 Ngterfal 5 Pending M MARCH 7 1 YES 2 NO ВҮ ON After t ELL 2 Accident 261. LOCATION (Street and Number or Rural Route Number City of Town, State) 26a. PLACE OF INJURY — At home, ferm, street, tactory, offica building, etc. (Specify) 3 Suicide ETED -10 DIRECTOR: hours after 4 Homicide 28 datarmined N.W. DI TREE Item 29a. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the bast of my knowledge. TO THE HOSPITAL D
TO THE FUNERAL DI
Be filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMINER: On the death occured at the time, date and placa, and due to the cause(a) and mannar as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RANCISC HYLE 10215 FERNWOOD Q 31. DATE FILED (Month, Day, Year) 13 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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RECORDS
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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
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			in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign		
	578-20-0744 1 9e. FACILITY NAME (If not institution, give street	□ M 2 🔀 F 7 9	YRS.			1/12/16		ryland		
TOR	Doctor's Comm. H			Lanha	OR LOCATION OF DE		rince	George's		
DIRECTOR	Md. 10b. COUNTY P.G. 10c. CITY, TO GLE							10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 5100 Glenn Da	ile Rd.		101	20769		-	J.S.A.		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Number Married 2 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	ENOENT OF HISPAN scify Cubert, Mexical 2 XNO Specify	Bla	14. RACE — American Indian, Black, White, etc. Specify: Black			
	15. DECEDENT'S EDUCATI (Specify only highest grade com-	ION Toletad)	16a. DECEDENT'S U	JSUAL OCCUPATION	ON .	16b. KIND OF BUS	INESS/INDUSTRY			
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COMPLETED	12th		Secreta	ıry		D.C. G	overnme	ent		
8	17. FATHER'S NAME (First, Middle, Last) Frederick Fle	tahor				ME (First, Middle, Maiden :				
H	19a. INFORMANT'S NAME (Type/Print)	coner	400 41441 1110							
2	Ruth Brayboy		9018	Volta	St.,La	nham, Md.	20706	=		
	20e. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	f from State cem	PLACE AND DATE O etery, cremetory or off Carmony	per plecel		DATE 20c. LOC	CATION — City or 1	COLUMN TO THE PARTY OF THE PART		
	21. SIGNATURE OF FUNERAL SERVICE LICENS		larmony	22. NAME AN	D ADDRESS OF FAC	CILITY				
	Carry it	Pratt	<u></u>			ngton & S ighs Ave.		С.		
TION	23. PART i. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, about, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of: Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
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ż	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	ON C	UNCERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATH	(Check only one)						
YSI	1 VES 2 (0 1	Inpatiant 2 - ER/Outp	etlant 3 DOA	4 - Nursing Hom	5 Residence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Natural 6 Pending	(Month, Day, Year)	28b. TIME INJU	RY WO	JRY AT RK? 'ES 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED			
ED BY	2 Accident Investigation 3 Suictde 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, at			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
E	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowle	edge, death occurred	at the time date	and place, and due	to the councies and man-				
COMPLETED		On the beele of axamination						e) and menner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	· ili.	3411		29c LICENSE NUM	BER 9	29d. DATE SIGNE	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DE	TH (ITEM 27) (Type, I	Print)	UBSC	1	4/6	1XV		
	T- CHATCHIEN 1	M.D. P.J. Y	11 Can	ningho	an It	ile Ger	Enyn Heglis WD			
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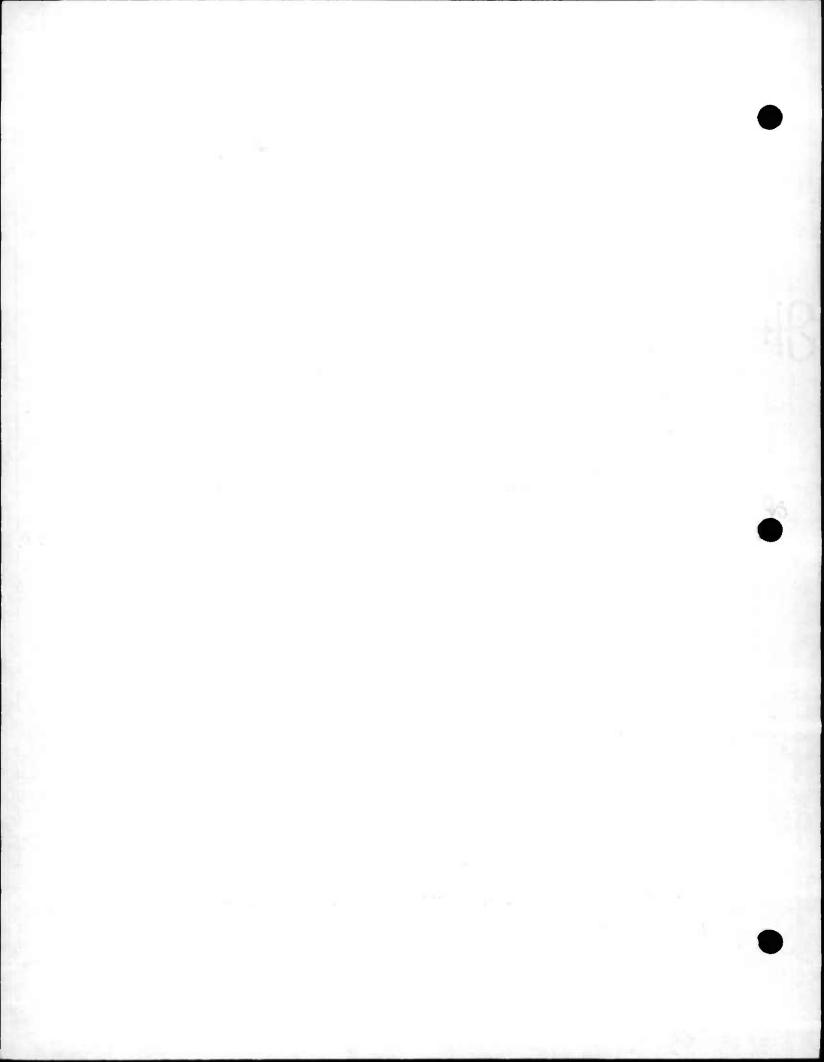


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT If them 28 is marked or them 23 shows any injury or other traumatic event the medical eventues much he existed of second

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CER	ΓIFICA	TE OI	FDEATH	RE	G. NO.				
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		4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birth	-	NDER 1 YEAR		7. DATE OF BI (Month, Day,	RTN	8. BIRT	NPLACE (State or Fore		
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S SHOUND		9e. FACILITY NAME (If not institution, give a	itreet and number)		9b. C	CITY, TOWN	OR LOCATION OF D			OUNTY OF			
,	O.	SACRED HEART F	HOSPITAL			CIMBE	ERLAND, M	D		LLEG	A MW		
-	5	RESIDENCE OF DECEDENT								TLEG	AUV 1		
10 10 10 10	DIRECTOR	Md Alleg			CITY, TOW						10d. INSIDE CITY LIMITS?		
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E.	Z.	106. STREET AND NUMBER 101. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?			
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	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	VER IN U.S. ARMEO		13. WAS DE	ECENDENT OF NISPA	NIC ORIGIN? (Spe	ecify Yea or No-	- 14. RAC	E — American Indian	,	
2	ВУ	3 🙀 Widowed 4 🗋 Divorced	IF YES, GIVE WAR				S 2 NO Specif			Jhi e			
28	60	15. DECEDENT'S EQU	CATION	Tue occupa	1								
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once.	COMPLET	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S NA			·			
a to		William Henry	Spiker				Charlo		inifre	,			
	B	19a. INFORMANT'S NAME (Type/Print)		Tab Ma	A INC. ADDO	F00 (0					21532		
notified	2	Wm. E. Ritchey	r	1540	2 L.C	Wer	George	Route Number, Cit	y or Town, State, Le Del	Zip Code)	21532 stburg,M	ra l	
8		20g. METNOD OF DISPOSITION											
must		1.23 Buriel 2 Cremation 3 Rem	oval from State	20b. PLACE AND D	or other ple	POSITION (/	Park Ap	DATE	20c. LOCATION	- City or T	tburg, Md		
		21. SIGNATURE OF FUNERAL SERVICE LIC	FASER	FIOSLDU					,1995				
examiner		22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home											
		Lonaconing, Md. 21539											
or removal medical		23. MATVI. Enter the diseases, or complications that caused the deeth, Do not enter the mode of dying, such as certific or respiratory arrest.										8	
me.		ahock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death											
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event,		DUE TO (OR AS A CONSEQUENCE OF):										KAP)	
Health and Mental Hygiene prior to burial, cremation, two any injury, or other traumatic event, the	z	- VIRGERS (VOILTE										4.5	
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P P	E	resulting in death) LAST											
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or H	> II	1 TES 2 NO	1. Inpatient 2 - EF	VOutpatient 3 D			me 5 🗆 Residence	6 Other (Spec	elfy)				
e d	표	27. MANNER OF DEATN	28a. DATE OF INJ (Month, Day, 1	URY 28b	TIME OF		JURY AT ORK?	28d. DESCRIBE	NOW INJURY	OCCURED			
marked	β	1- Natural 5 Pending 2 Accident Investigation			М		YES 2 NO						
		3 Suicide 8 Could not be	28e. PLACE OF IN building, atc.	IJURY — At home, fe (Specify)	rm, street, f	factory, offi	ce	28f. LOCATION City or Town	(Street and Num	ber or Rural	Route Number,		
hours after Item 28	ETE	4 Nomicide detarmined						Gilly Gr. John	r, orato)			1	
hours	_ 11	29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, death oc	curred at th	ne time, dat	e and place, and due	to the cause(a) a	and manner as	tated.			
be filed within 72 t	OMP	one) 2 MEDICAL EXAMINE	R: On the beele of exam	Instion and/or Investi	gation, in m	ny opinion,	death occured at the	time, date and p	lecs, and due to	the cause(e) and manner as state	ed.	
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Pog led	B	X	1 X/8	-							(Month, Day, Year)	- 1	
2 2 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										APRIL	47/75		
		DR. ROBERT WELIK,				CIIM	REDT AND	MD 2150	12				
- 1		31. DATE FILED (Month, Day, Year)	32. REGISTRARY		KL VE,	COPL	PEICHNIN)	AD 2130	12				
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the hospital or attending physician.	detached for use as the burial-transit permit. Pages 1,	once.
with nours after death. Page 6 may be retained by	pletery filled in by the funeral director, page 5 should by cremation, or removal.	ent, the medical examiner must be notified a
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIA	TO THE FUNERAL DIRECTOR: After this certi be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked, or

examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		In Carrie								9	5	13616
	1 - STATE REGISTRAR	STATE OF !	MARYLAND C	DEPAR	RTMEN'	OF H	DEA:	AND I	MENTAL HYGIE REG. N		30	b.o.d
	1. DECEDENT'S NAME (First, Mi									DAY	YEAR	3. TIME OF DEATH
	Thomas A. R	icker SR.	6. AGE (In yrs. Is	et hirthrian)	IF UNDER	1 VEAR	IF UNDE	0 94 MD6	April 18	190		1:40 PM HPLACE (State or Foreign
-3	215-20-5184	. Klus □e		69 yrs.		DAYS	HOURS	MIN.	(Month, Day, Year) FEB 6 1926		Country) MARYT.AND	
	9e. FACILITY NAME (If not inatitu	ition, give street and number)			9b. CITY	, TOWN	OR LOCAT				UNTY OF	
E C	CUMBERLAND NURSING HOME						RLAN				LLEGANY	
ĸ	RESIDENCE OF DECE	DENT									_	
DIRECTOR	MARYLAND ALLEGANY				LAVA		TION					10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
FUNERAL D	1049 NATIONAL HIGHWAY					10	215				S.A	WHAT COUNTRY?
B	11. MARITAL STATUS 1 □ Never Married 2 □ Merried 3 □ Widowed 4 □ Divorced 12. WAS DECEDENT EVER FORCES? ▼ ☑ YEIF YES, GIVE WAR OR U.S. ARMY			RMED NO		If yes, specify Cuben, Maxican, Puerto Rican, etc.) Blac				CE — American Indian, ck, White, atc.		
COMPLETED	15. DECEDE (Specify only his	ENT'S EDUCATION gheat grade completed)	(0	Give kind of	T'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY							
	Elementary/Secondary (0-12)	College (1-4 or 5	No.	e. Do NOT u	se retired.)							
N P	12		KEL	LY S	PRINC	GFIE	LD T	IRE	CO MANUF	. TIR	ES	
Ö	17. FATHER'S NAME (First, Middle	e, Last)				11.99	18. MOT	HER'S NA	ME (First, Middle, Maide	n Surneme)		
BE (GEORGE A. RI	CKER					AN	NA M.	ARIE WOOD	3		
	194. INFORMANT'S NAME (Type	(Print)	19	Db. MAILING	ADDRES	S (Street e			Route Number, City or To		(ip Code)	
2	ELIZABETH M.	RICKER	1	049	NATIO	DNAI.	HIGH	HWAY	LAVALE,	MARYI.	AND	21502
	20e. METHOD OF DISPOSITION 1 Department Department Department Other (Sp	3 Removal from State	20b. PLACE cemetery, cr SUNSE	AND DATE	OF DISPOS	SITION (Na	ame of		DATE 29c. I	OCATION -	- City or T	
	21. SIGNATURE OF FUNERAL S	H	2 0111	22. MI	NAME A	TT-A	DAMS		EMOH			

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final ardiac disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Chimic BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 - YES 2 - NO

WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (Check only one)								
t YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpetient			8 Other (Specify)						
MANNER OF DEATH Natural 5 Pending Accident Investigation	HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA DIMER: Nursing Home 5 Residence 8 Other (Specify) EATH 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME DF INJURY WORK? M 1 YES 2 NO NO NO NO NO NO NO	28d. DEŞCRIBE HOW INJURY OCCURED								
2 Culate	28e. PLACE OF INJURY At h	nome form street fact	iony office	281 J OCATION (Street and Number or Burn) Bouts Number						

29e. CERTIFIER
(Check only one)

SertiFyING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, end due to the cause(e) and manner ee stated.

es stated.

	or exemination endor investigation, in r	ly opinion, death occured at the time, date and place	e, and due to the cause(s) and manner as stated
296. SIGNATURE AND TITLE OF CERTIFIER	Holmer	29c. LICENSE NUMBER	29d. DATE SIGNED (Morith, Day, Year)

10

	100110	/ / / /	7
202	Schlegst	Cumberle	end, Ad.

404 DECATUR STREET CUMBERLAND

31. DATE FILED (Month, Day, Year) APR

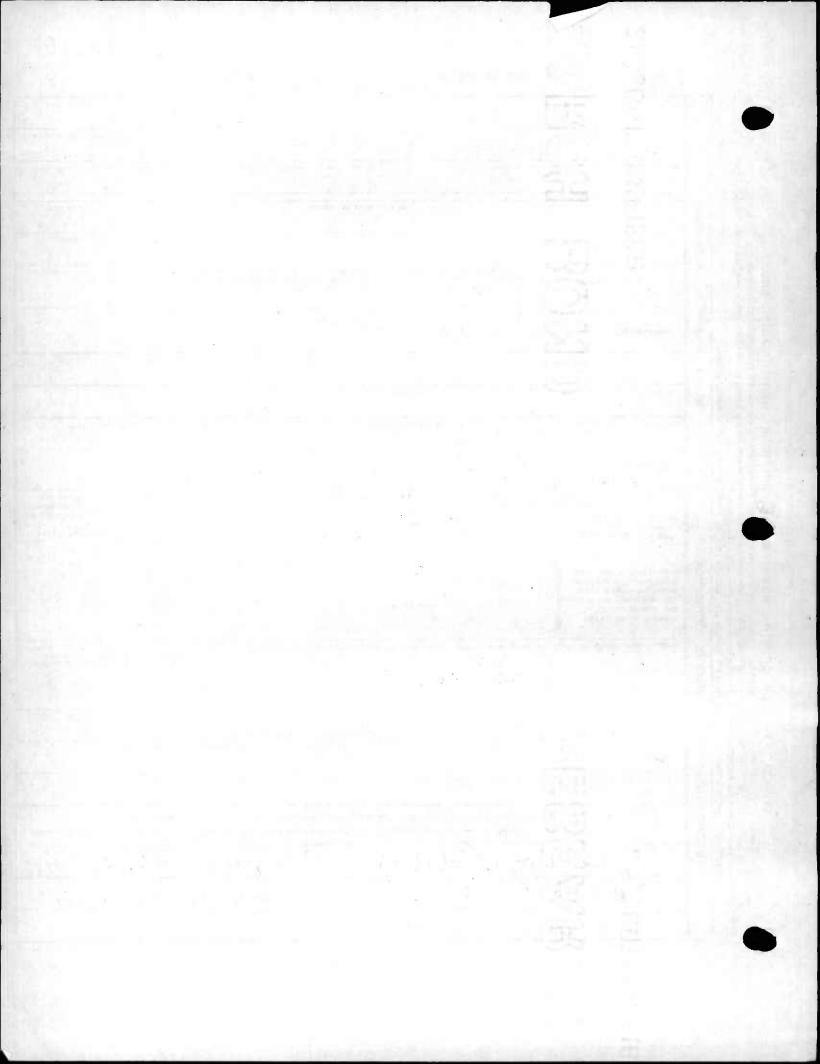
4 Homicide

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(6)

32. REGISTRAR'S SIGNATURE

Approximate



BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death, Page 6 may be retained by the boss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

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3 should

							9	5	13617	
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTA			MENTAL HYGII				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH	
	KENNETH RALPH RA	AT				APRIL 2	23 19	95	1:45P M	
		SEX 6. AGE (In y		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year, June 3,		6. BIRTHI Country Ut		
	9a, FACILITY NAME (If not institution, give street	and number)	98	. CITY, TOWN	OR LOCATION OF DE			9c. COUNTY OF DEATH		
DIRECTOR	National Institute	of Health		Beth	esda		Mon	tgom	ery	
HE	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCA	TION	10d. INSIDE CITY LIMITS?				
		Salita Alia							1 X YES 2 NO	
FUNERAL	10e. STREET AND NUMBER			10	1. ZIP CODE		10g. CITI	ZEN OF W	NAT COUNTRY?	
W		109 North Deodar Street 92705								
BY FU	11. MARITAL STATUS 1	S. ARMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify					- American Indien, White, etc. White		
	15. DECEDENT'S EDUCATION	a. DECEDENT'S US	JAL OCCUPATI	ON	16h KIND OF	BUSINESS/IND	USTRY	wiitre		
COMPLETED	(Specify only highest grade comp Elementary/Secondary (8-12) Co	pleted) ollege (1-4 or 5+)	(Give kind of work life. Do NOT use re	done durina m	ost of working	Killio OF		- writt		
IPL	Listing (0-12)	5+	Attor	ney		Law				
O	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAI	ME (First, Middle, Maid	ien Surname)					
BE C	Constant Dest					Zonderv	on			
	19a. INFORMANT'S NAME (Type/Print)		al Route Number, City or Town, State, Zip Code)							
2	Darlene Raat				Deodar St				a. 92705	
STATE OF THE STATE	20e. METHOD OF DISPOSITION 1	from State 20b.PL	ACE AND DATE OF D y, crematory or other chaven M	ISPOSITION (N place) EMOria	ame of 1 Park	1	anta A			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	ed			ND ADDRESS OF FAC					
	· Greya S. +	Lan-		313	ldson Fur Talbott <i>H</i>	Avenue L	aurel,	Md.	20707	
	23. PART I. Enter the diseases, pr comp	plicetions thet caused th	e death. Do not	enter the mo	de of dying, such	as cerdiec or re	spiretory arr	est,	Approximate	
	ehock, or heert fellure. Liet Dnly one cause Dn each line. IMMEDIATE CAUSE (Finel								Onset end Desth	
	disease or condition resulting in deeth)	(F	rebr	nl	Int	autic	7-		1301	
	a	DUE TO (OR AS A CO	NSEQUENCE OF):			n and so			1301	
z		7	humb	o en	2501,8	n			301	
RTIFICATION	Sequentielly list conditions, If smy, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
2	CAUSE (Disease or Injury c. —	60	int so	home					Yeary	
E	thet initieted evente resulting in desth) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):							
CER	d.									
PHYSICIAN: MEDICAL C	PART II. Other significent conditions co	intributing to death but	not resulting in t	he underlyin	g ceuse given in l	PERI	AN AUTOPSY FORMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
. ME	DID TOBACCO USE CO	NTRIBUTE TO C	ALISE OF D	NEATH Y	ES I NO				1 Li YES 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL		TOOL OI L		LACE OF DEATH (Che					
S	EXAMINER? 1 YES 2 NO 1	OSPITAL:		THER:	ne 5 🗆 Residence	8 Other (Specify)				
둙	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. IN.	JURY AT	28d. DESCRIBE HO	W INJURY OCC	URED		
BY	1 X Natural 5 Pending 2 Accident Investigation	III.		YES 2 NO						
	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stree	t, factory, offic	•	281. LOCATION (Stree City or Town, Str	et and Number ste)	or Rural Ro	oute Number,	
COMPLET		l: To the best of my small								
8		n the basis of examination an	prof investigation, is	n my opinion, o	leath occured at the	time, data and place,	and due to the	e cause(s)	and manner as stated.	
BE	39h. SIGNATURE AND TITLE OF CHECKIER	UV.			29c. LICENSE NUM	/	29d, DATE	SIGNED (aginer, Day frains	
O NAME AND ADDRESS OF DERSON WHO COMPLETED CAUSE OF PERTY STEP OF SECURITY OF										

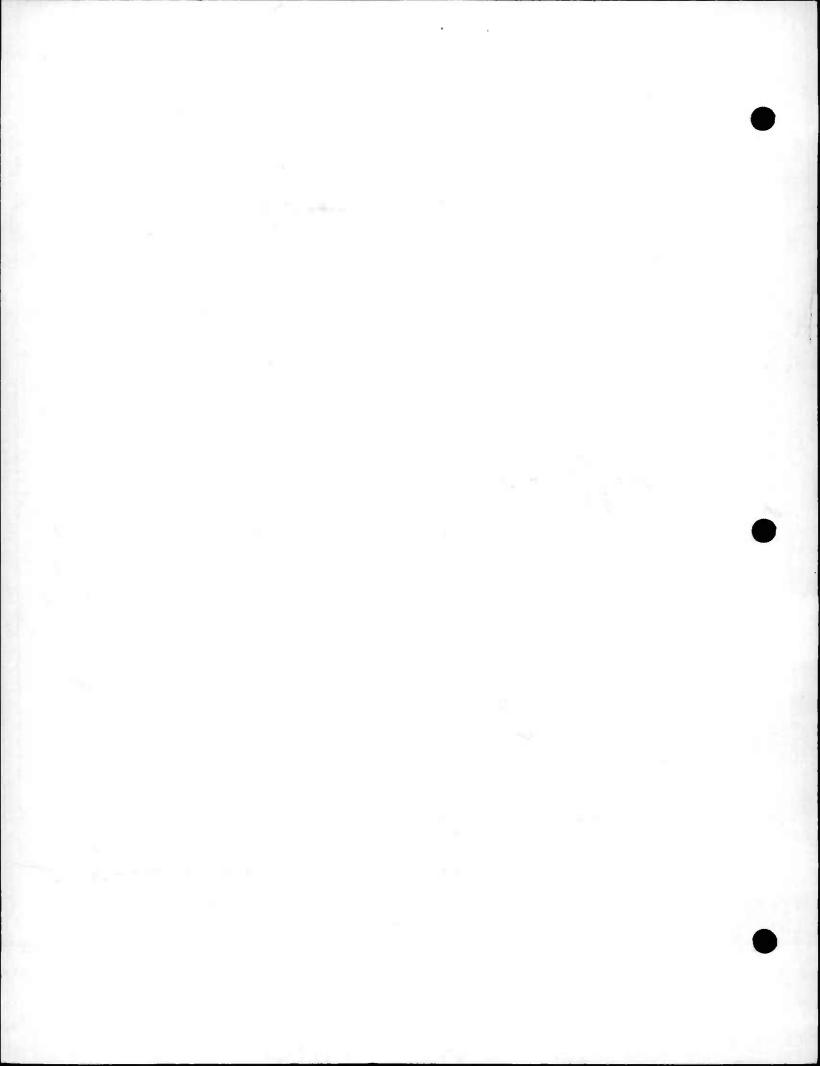
5. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Campatient 2 ER/Outpatient	28. PLACE OF DEATH (Check only one) TAL: atlent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)										
7. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED								
3 Suicide 8 Could not be detarmined	28s. PLACE OF INJURY — At h building, atc. (Specify)	ome, farm, street, fac	tory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TET WEI CHAN, M.D.

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND

31. DATE FILED (Month, Day. 71995 32 REGISTRAR'S EIGNATURE

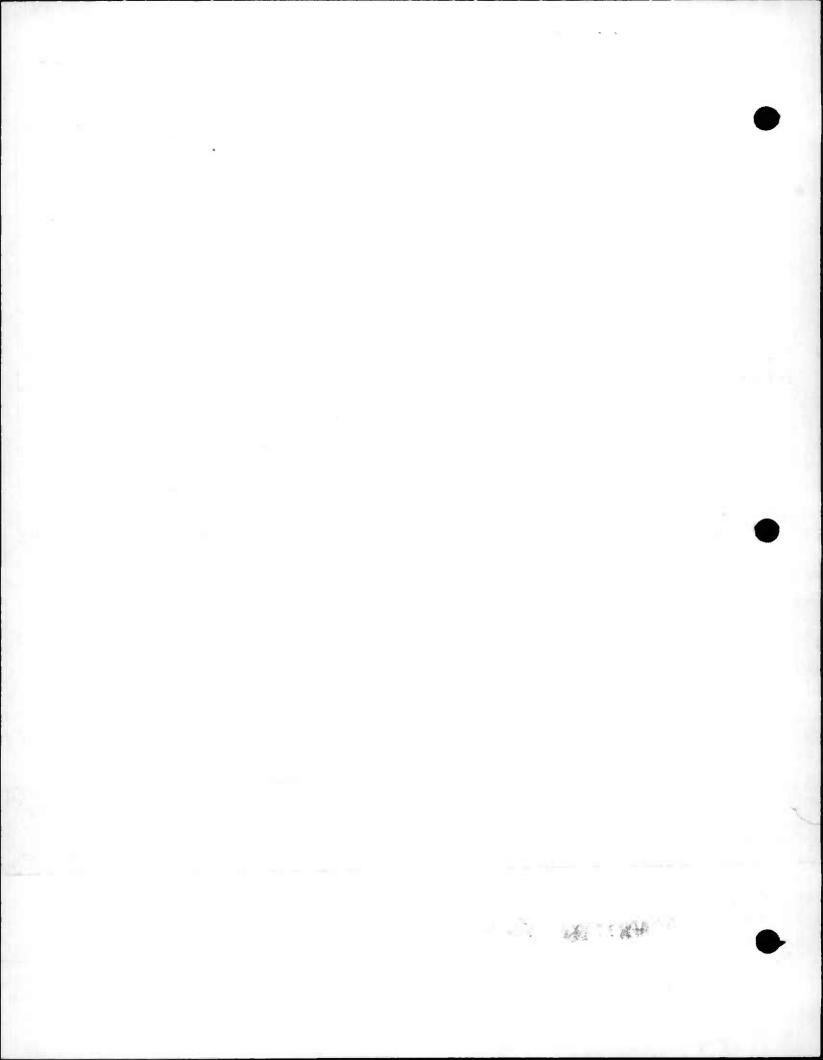


D. REGISTRAR'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flow that death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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										9	15	136	18
	FOR 1 - STATE REGISTRAR	STATE OF M			RTMENT OF				YGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF C	DEATH			3. TIME OF D	EATH
	Ella Jones	SPICE	R					April		199	95	8:13	37 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER 1 YE			7 DATE OF B		1905	a BIRTH	PLACE (State o	
	578-50-4188	1 □ M 2 🂢 F	89	YRS.	MONTHS DA	YS HOURS	MM.	Sept.	13	, 1905 Country) , 1905 Alabama			
	9e. FACILITY NAME (If not institution, give a				9b. CITY, TO	WN OR LOCATIO	ON OF DE	ATH			INTY OF D		
9	Doctor's Communit	ty Hospit	al		Lanha	ım				Pr:	ince	George	's
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	ν		10c CIT	V TOWN OR L	CATION							
DIRECTOR	Maryland Princ	ce George	1 -			TOWN OR LOCATION 10d. INSIDE CITY LIMITS?							
	10e. STREET AND NUMBER	e George	<u>S</u>	1 KI	<u>rerdale</u>	10f. ZIP CODE				10a CIT	17EN OF W	1 ∑ YES 2 /HAT COUNTRY	
FUNERAL	6321 Kenilworth	Avenue				2073				7.0		THAT COUNTRY	, ,
S	11. MARITAL STATUS	12. WAS DECEOENT			13. WAS			U.S.A. PANIC ORIGIN? (Specify Yee or No				— American I	ndlen
	1 Never Married 2 Married	FORCES? 1	YES 2 X	NO	If yes	, specify Cube YES 2 ∑ NO	n, Mexica:	n, Puerto Rican	, etc.)		Black Specif	, White, etc.	
) BY	3 Widowed 4 Divorced	<u> </u>				XX	,				op son	Whit	e
Ä	15. DECEOENT'S EDU (Specify only highest grade	CATION completed)	16a. Di	ECEDENT'S Bive kind of	USUAL OCCUP work done during se retired.)	ATION most of workin	g	16b. KIN	O OF BUS	INESS/IN	DUSTRY		
"	Elementary/Secondary (0-12)	College (1-4 or 5 +	,										
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1 41	brari	Lan						es Go	vernme	nt
	Alvin Staley Jone	9.5						ME (First, Middle		,			
BE	19a. INFORMANT'S NAME (Type/Print)		+6	b MAILING	ACCRECE (CH			Pearl			A 100		
2	Curtis J. Spicer											0111/	
	20a. METHOD OF DISPOSITION		20h DI ACE	ANDOATE	OF DISPOSITION	A (Nemo of		Crofto	200 100	MONTA	Otto To-		
	1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	Fort	I in C	ther place)	neterv	04/	17/95	Bro	ntra	od N	forevilar	- d
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	2/	HILITO	22. NAM	E ANO ADDRES	S OF FAC	CILITY					
	· Charles	F. Be	11		4739	Balti	more	s Sons	Hva	tter	71110		
	23. PART i. Enter the diseases, or a	complications that	caused the de	eath. Do i	not entar tha	mode of dyi	ng, suct	as cardiac	or reapi	ratory ar	rest,	Арргох	lmata
	ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onest and Death												
	disease or condition reauiting in death)	· KE	SPIR	17	OK	P F	-A	120	Kt			121	-day
	DUE TO (OR AS A CONSEQUENCE OF):										0		
8	Sequentially list conditions, Oue TO (OR AS A CONSEQUENCE OF												
CERTIFICATION	if any, leading to immediata cause. Entar UNDERLYING	E Al	F O	-L A	IND	AT	1-41	1.					
윤	CAUSE (Disease or injury that initiated events	c. OUE TO	OR AS A CONSE	OUENCE O	NOT	///	1 1	1					
E	reaulting in death) LAST				,			/				j	
빙		0.										+	
AL:	PART II. Other significant condition	a contributing to	daath but not	resulting	in the underi	ying cause g	ivan in I	Part i. 24s.	WAS AN A		24b.	WERE AUTOPS	
8	- non;	d	Wor	0	200	20	0	10	YES 2	10		COMPLETION CO	
M					- CC	ーシル	K.					1 - YES, 2/	ON
ä	DID TOBACCO USE CONTI	RIBUTE TO CAL					ERTAIN	1 150				NI	7
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	28. PLA	CE OF DEAT	OTHER:	one)							
IYS	1 AYES 2 NO 27. MANNER OF DEATH	1 Inpetiant 2 🗆	ER/Outpetient 3		4 Nursing I		aldenca (8 Other (Spe	iclfy)				
	1 Netural 5 Pending	28e. DATE OF I		286. TIM	URY	INJURY AT WORK?		28d. DESCRIB	E HOW IN	JURY OC	CUREO		
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a PLACE OF	INJURY At he	Transis in the second		YES 2	NO		1.00				
COMPLETED	4 Homicide 8 Could not be detarmined	building, s	tc. (Specify)	rine, territ, t	straut, tactory, c	MICE		281, LOCATION City or Tox	vn State)	nd Number	r or Rural Re	oute Number,	
PLE	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of r	ny knowledge, de	ath occurr	ed at the time, o	iate end place,	end due	to the cause(e)	end men	ner as stat	led.		
MO	one) 2/ MEDICAL EXAMINE	R: On the beele of ex	mination end/or	Investigatio	n, in my opinio	n, death occur	ed at the t	time, date end	placa, and	due to th	re cause(e)	end manner e	e atated.
EC	29b. SIGNATURE AND TITLE OF CERTIFIER		10	_		29c. LICE						(Month, Day A)	er)
Φ		O M	~	N)		10-	30	152	5	M	AVI	-100	190
2	30. NAME AND ADDRESS OF PERSON WHI	O COMPLETEO CAUS	E OF OEATH (TE	M 27) (Typ)	Print)	10 11.	A	1400	0. 6)6.		100	10
	27-Kao, M	401	OR JULIAN	MTC	rech	W M	SCITE !	1#22	Uik	THE	16-1	シーン	0110



BALTIMORE, MARYLAND 21215-0020 mours after death. Page 6 may be retained by the hospital or attending physician.

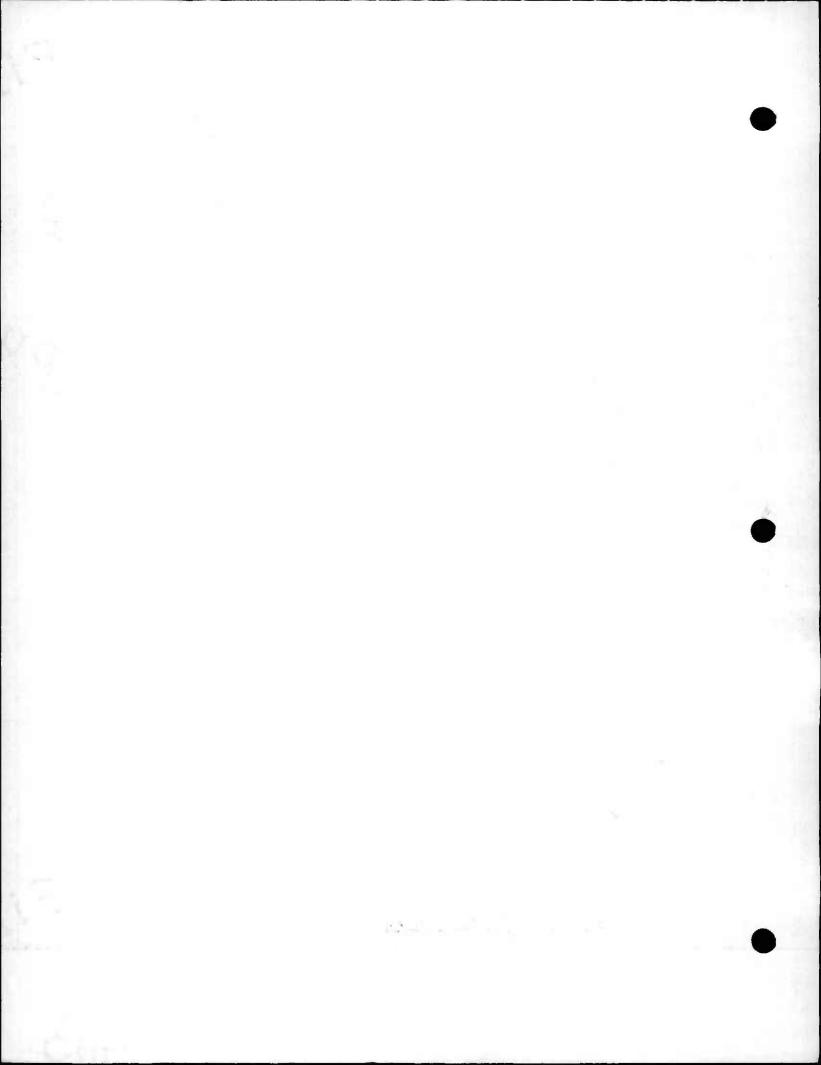
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE REGISTRAR	STATE OF	MARYLAND			OF HEALI		MENTAI	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Midd	le, Last)							OF DEATH			3. TIME OF DEATH	1
	BEATRICE	M.	SCHR	EINER				APRTI	15,		YEAR	2:58	PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		DER 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or For	eign
	179-01-1774 9a. FACILITY NAME (If not institute	1 M 2 X	75	YRS.	MONTHS Sh CITY	DAYS HOUR		NOV.	24, 1			AWARE	
DIRECTOR	10716 PINEY IS	LAND DRIVE				HOPVILL				9c. COUNTY OF DEATH WORCESTER			
EC		COUNTY		10c. CIT	10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY	
픕	MARYLAND W	ORCESTER		BIS	BISHOPVILLE							LIMITS?	NO
AL	10e. STREET AND NUMBER				101. ZIP CODE					10g. CIT	ZEN OF V	WHAT COUNTRY?	
ER	10716 PINEY ISLAND DRIVE				21813					U:	SA		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 X			ARMED	13.	WAS DECENDEN	T OF HISPAI	NIC ORIGIN	? (Specify Yes	or No-	14. RACE	— American India:	n,
ВУ	1 Never Married 2 Marri 3 X Widowed 4 Divorced		E WAR OR DATES	JNO		If yes, specify C			rican, etc.)		Speci		
		T'S EDUCATION	140.									WHITE	
COMPLETED	(Specify only high	est grade completed)		DECEDENT'S (Give kind of ite. Do NOT u	work done i	CCUPATION during most of wo	orking	186.	KIND OF BUS	INESS/INC	DUSTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or	5+)	NER &	,	O A TOD		M	TEL				
M O	17. FATHER'S NAME (First, Middle,	Lest)	OWI	MER G	OFER		OTHER'S NA		Aiddle, Maiden	Cummanal			
	WILLIAM GODFR						ZABET			Surname)			
BE	19a. INFORMANT'S NAME (Type/Pr			19b. MAILING	ADDRESS	(Street and Num				State 7ie	Code		
2	PAUL D. FRANK		- 1										
	20a. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of DATE 20c.) OCATION — City of Town							wn. State					
	1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EVERGREEN CEMETERY 4/19/95 BERLIN, MA												
	21. SIGNATURE OF FUNERAL SER	VICE LICENSEE	1	riores.		NAME AND ADD	RESS OF FA		7103	DUIG	1119	HILLIMIND	
	► 1'16 D	111 21	25		1774	CTTNCC	EUNE	DAT T	TOME	CET DY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TP DE 14	0075
	23. PART I. Entar tha diseas	es or complications	that caused the	faeth Do								LE, DE.19	
	shock, or heart t	allure. Liet pniy one	ceuse on each ili	1e.	inot ariter	the mode of	dying, suc	n as card	nac or respi	ratory an	rest,	Approxima interval Be	tween
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)									Onset and	Death		
	resulting in death)	-	TO (OR AS A CONS									peca	0-
		_	10 (011 /10 /1 00110	CO CINCE O	τ.								
0	Sequentially list conditions, If any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):												
PA	cause. Enter UNDERLYING	J .											
Ĕ	CAUSE (Diseese or injury that initieted evente	DUE	TO (OR AS A CONS	EOUENCE O	F):								
CERTIFICATION	resulting in deeth) LAST	d											
	PART il. Other significent co	onditions contributing	to death but not	resulting	in the un	derlylna caus	e given in	Part i	24s. WAS AN	AUTOREV	245	. WERE AUTOPSY FIN	DINOG
S						aony mg oad	o given in		PERFOR	MED?	240	AVAILABLE PRIOR T	0
								_	1 [] YES 2	NO		OF DEATH?	Wat
Σ	DID TOPACCO	LICE CONTRIB	ITE TO CA	1165 0	F BEA	711 1/70		/				1 YES 2 N	°
A	DID TOBACCO 25. WAS CASE REFERRED TO MED		DIE 10 CA	OSE O	r DEA	26. PLACE OF		- 1	-1				
PHYSICIAN: MEDICAL	EXAMINER?	HOSPITAL:	2 ER/Outpetient	2 🗆 504	OTHER	1 :	1		,				
ξ	27. MANNER OF DEATH		DF INJURY	28b. TIM		28c, INJURY AT		_	CRIBE HDW II	LILIBY OC	CHBED		
	1 Netural 5 Pendi	ng	n, Day, Year)		JURY M	WORK?		200, 520	OTHER TIP II	100/11 00	COMED		
ВУ	3 Couloide	igation 28a. PLAC	E OF INJURY — AI	homa, larm,	street, fact			281, LOC	ATION (Street a	nd Number	or Rural F	Toute Number	
COMPLETED	4 Homicide detarm	not be buildi	ng, atc. (Specify)						or Town, State)		0. 7.0.07	10010	
2	29a. CERTIFIER 1 CERTIFYIN	G PHYSICIAN: To the bes	ol mu knowledge	death assu				116420					-
MP		XAMINER: On the basis										and menner on eter	
	29b. SIGNATURE AND TITLE/OF C	/_							wito praca, an				ned.
BE	The signature and try Legoly C	A V				29c. l	LICENSE NUI	WBER CA	0/)	29d. DAT	SIGNED	(Month, Day, Year)	_
2	30. NAME AND ADDRESS OF PER	SON WHO COMPLETED O	AUSE OF DEATH #17	'FM 27\ /5	Drint1) He	UT			41	12/8	
	CRAIG J. S.	CHAEFER.	551	AR).	SIDE.	De.	SA	LISBU	٤٠.	MA	, 21801	- 1
	31, DATE FILED (Month, Day, Year) APR 18	1995 Jaly	THAR'S SIGNATURE	Randall						-			



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687	requires that the death certificate be executed within mounts after death. Page 6 may be retained by the hospital or attending physician
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AL	e law
Ė	N: Th
VISION OF VITAL RECORDS, P.O. BOX 68760,	ATTENDING PHYSICIAN
N O	ING P
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TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed withing a flow requires that the death certificate be executed withing and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

							9	5	13620	
	1 - STATE REGISTRAR	STATE OF MARY!			HEALTH AND	MENTAL HYGIEN	E			
- 1	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		:	. TIME OF DEATH	
	VIRGIL LEE	SWICK				APRTI 24		YEAR	1)00 NOUL	
			(In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7, DATE OF BIRTH	199		LACE (State or Foreign	
	000 04 5450	1 🖳 M 2 🗆 F	vne	MONTHS DAY		(Month, Day, Year)		Country)		
	233-34-7436		70 113.			MARCH 14.			T VIRGINIA	
~	9e. FACILITY NAME (If not institution, give street	it and number)		9b. CITY, TOW	N OR LOCATION OF O	DEATH	9c. COUI	NTY OF DEA	ATH	
Ö	3316 HALTER ROAD			WEST	MINSTER		CA			
ត្ត	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY		10.00	Y. TOWN OR LO						
DIRECTOR	Total Gooding	0.7.7		.,				1	0d. INSIDE CITY LIMITS?	
	MARYLAND CARR		WE	STMINS				1	YES 2 NO	
₹.	10e. STREET AND NUMBER				10f. ZIP COOE		10g. CITI		AT COUNTRY?	
FUNERAL	3316 HALTER ROAD	21158	3		USA					
5		IN U.S. ARMED	13. WAS (ECENDENT OF HISPA	NIC ORIGIN? (Specify Yea	or No-	14. RACE -	- American Indian, White, atc.		
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 , YES	DATES	1 0	ES 2 NO Speci	en, Puerto Ricen, etc.)	-	Specify:		
	3 Widowed 4 Divorced	WORLD WAR I	II	X				, ,	ASTAN	
	15. DECEOENT'S EDUCAT (Specify only highest grade co	FION (moletect)	16a. DECEDENT'S	USUAL OCCUP	ATION	16b. KINO OF BUS	INESS/INC			
E		College (1-4 or 5+)	life. Do NOT us	e retired.)	most or working					
AP	9th		INSTALL	ER		ELECTR	ICAL	MANUE	FACTURER	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden				
	GLENN	SWICK			RHODA	CATHER				
BE	19a. INFORMANT'S NAME (Type/Print)	DWICK	19b. MAILING	AODRESS (Stra					RATCHFORD	
5	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, S 197. MARWOOD ROAD TOWSON, MARYI,								I	
	20s. METHOD OF DISPOSITION							2120		
	1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	el from Stata Car	b. PLACE AND DATE (metery, crematory or o	ther place)		OATE 20c. LO	CATION —	City or Town	n, Stata	
	21. SIGNATURE OF FUHERAL SERVICE LICEN	ĮV.	APLE HIL			4/27 PET	FRSBI	URG, I	W.V.	
	. 1) 4 :			22. NAME	ANO AODRESS OF FA		יי דאם	OMT TO	RE STREET	
	1. Nevy	Ludy	-	CIZ	TOO DINNER	ISO III	TUU		RE STREET	
	23. PART I. Enter the diseases, or con	ngricetions that ceuse	d the death. Do r	ot enter the	mode of dylng, suc	Ch as cerdled or respl	VIE.A.I.	JWN P	Approximate	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or research, or heart failure. List only one cause on each line.							· · · · · · · · · · · · · · · · · · ·	interval Between	
	iMMEDIATE CAUSE (Final disease or condition	Catalia	. 0 4	Pord	/	1. 1.		_	Onaet and Death	
	resulting in death) a	wersos	Molic	rotic Cardio vascular di					OB	
	OUE TO (OR AS A CONSEQUENCE OF):									
8	Sequentially list conditions.									
Ě	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS	A CONSEQUENCE OF	7):						
2	CAUSE (Disease or injury	100 11 (120)								
Ë	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	7):						
CERTIFICATION	d									
_	PART II. Other aignificant conditions of	contributing to death	but not resulting	n the underly	Ing cause alven in	Part I. 24s. WAS AN	ALITOREY	Task W	/ERE AUTOPSY FINDINGS	
8					g caeco given in	PERFOR		A	WAILABLE PRIOR TO	
<u> </u>						1 [YES 2]	NO D		OMPLETION OF CAUSE OF DEATH?	
Σ								1	☐ YES 2 NO	
ž	DID TOBACCO USE CONTRIE	BUTE TO CAUSE C	OF DEATH YE	S NO	UNCERTAI	N 🗆		1	<i>'</i> .	
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	28. PLACE OF DEAT		(e)					
PHYSICIAN: MEDICAL		☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	OTHER: 4 Nursing H	ome 5 X Residence	8 Other (Specify)				
ΞI	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM		NJURY AT	28d. DESCRIBE HOW IN	JURY OCC	CURED		
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJ		WORK?				· ·	
À	2 Culate	28s. PLACE OF INJURY	Y — At home, term, s	treet, factory, o	fica	28t. LOCATION (Street a	nd Number	or Bural Box	the Mumber	
	4 Homicide 8 Could not be	building, etc. (Spe	ocify)			City or Town, State)	,			
iy	29a, CERTIFIER									
A P	(Check only	N: Toythe best of my know								
COMPLETED	2 MEDICAL EXAMINER:	oprine beels of examination	on and/or investigation	n, in my opinior	, death occured at the	time, data and place, and	due to the	a cause(a) a	nd manner as stated.	
BE	296. THOMATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER /	29d. OATE	E SIGNED (N	fonth, Day, Year)	
					1)14.	209 (M)	► AD	PRIL 2	25, 1995	
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CALISE OF OL	EATH /ITEM 27) /Ema	Deinet		1	AF	*/TT/ C	J, 1770	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D. 212 WASHIGTON

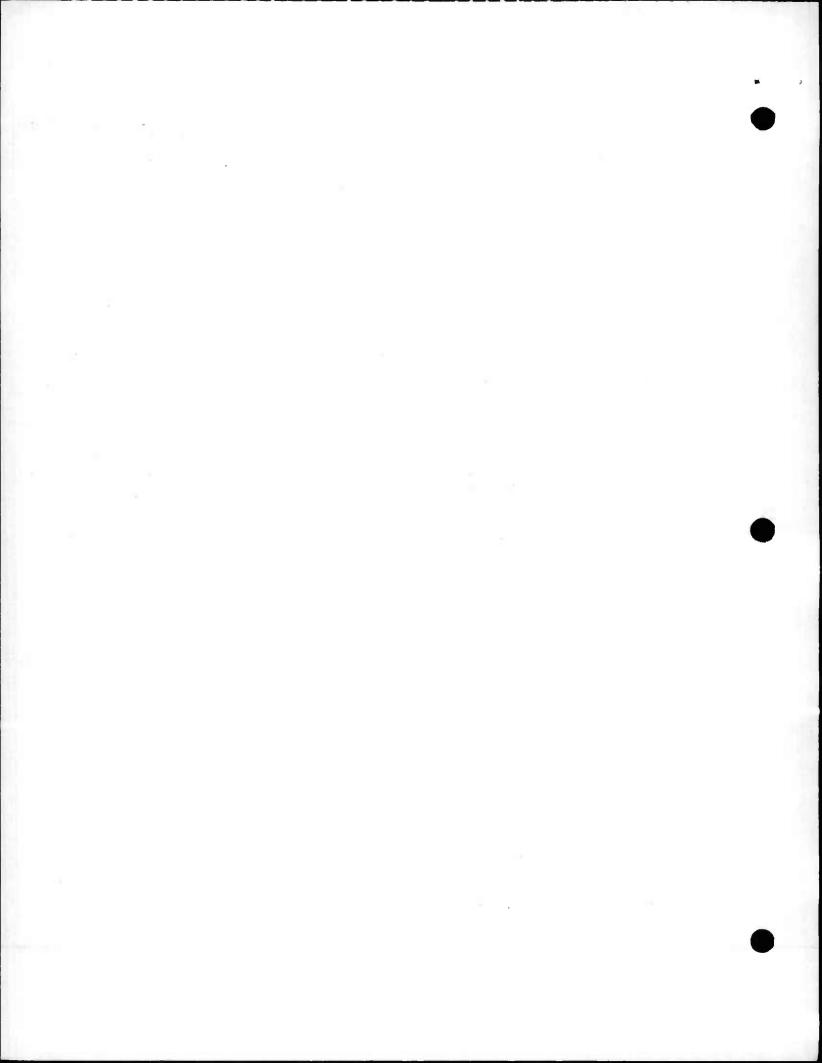
32. REGISTRAR'S SIGNATURE

Falso d'Author Revolution

HEIGHTS

WESTMINSTER, MARYLAND

SANG Y. RHIM.
31. DATE FILEO (MORTH, Day, Year)
APR 25 1995



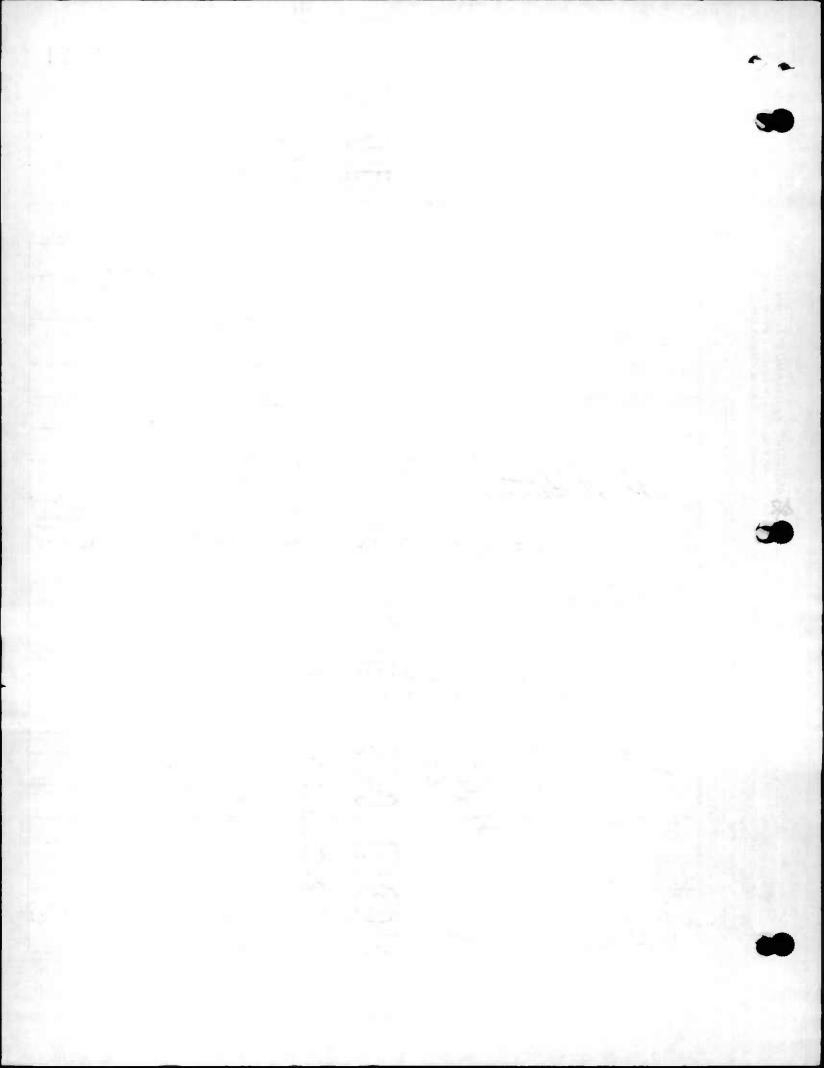
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5	within 72 hours after death with the St.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND	DEPARTMENT	OF HEALTH	AND MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	ГН	REG. NO.

1 - STATE REGISTRAR	STATE OF MARYLA		IENT OF HEAD		MENTAL HYGIENE		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
Sophia El	eanor SChub	ert				, 1995	5:00P.M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In			UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign
195-18-7975		2 YRS.	CITY, TOWN OR LO	URS MIN.	July 241	922 Pi	ttsburg, Pa.
CARROLL COUNT		1.41		MINST		CARR	
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	γ	10c CITY TO	OWN OR LOCATION				10d. INSIDE CITY
	Carroll		tminste	r			LIMITS?
10e. STREET AND NUMBER	Cullott	Wes	10f. ZIP			10g. CITIZEN OF	WHAT COUNTRY?
30 Locust St.	Apt 308			21157		U.S.	
11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED		ENT OF HISPAN	IIC ORIGIN? (Specify Yee	or No- 14. BAC	CE — American Indian,
1 Never Married 2 Merried 3 🔀 Widowed 4 🗌 Divorced	FORCES? 1 YES			Cuben, Mexica ZNO Specify	n, Puerto Rican, etc.)		ck, White, etc. polly: White
15. DECEDENT'S EDI		18e. DECEDENT'S USL	JAL OCCUPATION		16b, KIND OF BUS	INESS/INDUSTRY	
(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during most of tired.)	working			
12		Hous	sewife		Hom	emaker	
17. FATHER'S NAME (First, Middle, Last)			18.	MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
Matthew	Seborosk	i	E.	leano	r		- Sec
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD			Route Number, City or Town		
Jerome A. Sch	ubert	1511 [Dulany 1	Rd. F:	inksburg,	Md. 2	1048
20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Cremation 3 ☐ Ren		PLACE AND DATE OF				ATION — City or	
4 Donetion 5 Other (Specify)		emetary, cramatory of			4/25 Har	npstead	l, Md.
21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		Eletch		cury Ineral Ho	71.0	21157
Many X.	teleher						minster, Md.
23. PART I. Enter the diseases, or shock, or heert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. CEREBR DUE TO (OR AS A b. DUE TO (OR AS A	ch line.					Approximate Interval Between Onact and Death
Sinto		nt not resulting in the Person	Tus	use given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	Nb. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	100	26. PLACE	OF DEATH (Ch	eck only one)		
1 YES 2 NO	1 Department 2 ER/Outpo	ntlent 3 DOA 4	☐ Nursing Home 5		6 Other (Specify)		
27. MANNER OF SEATH 1	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WORK?	AT NO	28d. DEŞCRIBE HOW II	NJURY OCCURED	
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	284 DI ACE OF IN HIEV	- Al home, farm, stree	et, factory, office		261. LOCATION (Street e City or Town, State)	and Number or Rum	I Route Number,
acel comp	SICIAN: To the bast of my knowl						e(e) end manner ee stated.
HANDINATURE AND TITLE OF CERTIFI	y Naga	Mile]	c. LICENSE NU	MBER LOO	P 4 2	ED (Month, Day, Year)
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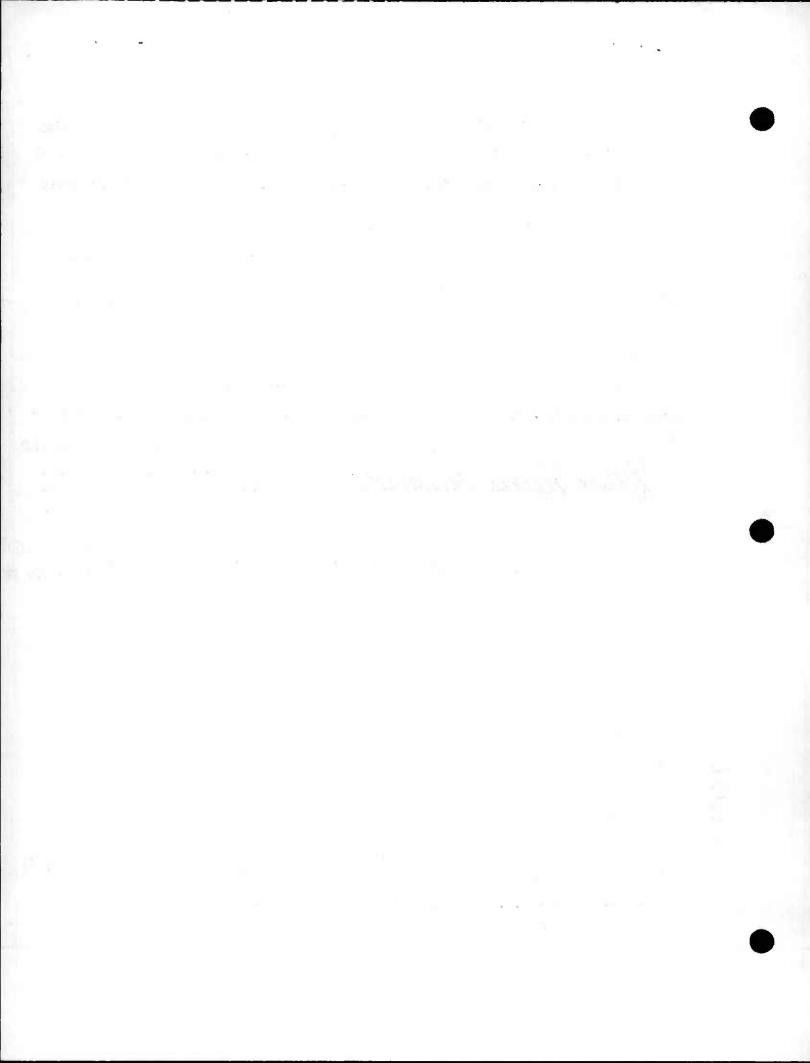


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DIVISION OF VITAL RECORDS, I	(
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Lest) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Lillian B. Spicer April .995 1145 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Dec. 13, Maryland 216-03-2369 1 M 2 X F 82 1912 Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Dorchester Taylors Island 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 3 21669 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Ricen, atc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black White etc. 1 Never Merried 2 Merried BY 3 X Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ve kind of work done Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) COMPL 12 Clerical Moving and Storage once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) notified at BE Joseph Kraus Catherine Buck 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Neild, 5110 North Drive, Cambridge, MD. 21613 pe 20e. METHOD OF DISPOSITION
1X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Donation 5 Other (Specify) . GraceEpiscopalChrchCem4-24 Taylors Island, MD the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Curran-Bromwell Funeral Home, P.A. MWWW 308 High St., Cambridge, MD. 21613 the 23. PM 1 Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 3 filled in t Interval Between 6 IMMEDIATE CAUSE (Final Onset and Daath cremation, disease or condition resulting in death) Iver completely event, DUE TO (OR AS A CONSEQUENCE OF burial, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) 9 if any, leading to immediate physician cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST the attending I attending Injury, or PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and and AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? shows any signed Health a 1 TES 2 KNO 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has b. Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem State HOSPITAL: EXAMINER: certificate OTHER: 1 YES 2 NO Unpatient 2 ER/Outpatie nt 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) marked, or the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED this c 1 Natural 1 YES 2 NO ВY death Investigation After 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 COMPLETED 6 Could not be DIRECTOR: after 4 Homicide 28 hours Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, date end piece, and due to the cause(e) and menner ee atated. THE HOSPITAL
THE FUNERAL (
filed within 72 h TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II (Check only one) MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 8 F181 20 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jose M. deLeon, M.D. 505 Byrn Street Cambridge, MD 10 21613 31. DATE FILED (Month, Day, Year)

32 REGISTRAR'S SIGNATURE whi atwoles Kardall



1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 Elsie Mae moth april 2032 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (In yrs last hirthday IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 | M 2 + F DAVE HOURS 217-30-8017 88 Mar. 22. 1907 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH Se. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Worcester Pocomoke City Md. permit. 1 TYES 2 NO FUNERAL 10e STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 429 Bank Street Pocomoke City, Md. use as the burial-transit 21851 United States hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 DIO 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Ricen, etc.)

1 YES 2 NO Specify: **BALTIMORE, MARYLAND 21215-0020** 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EOUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INOUSTRY funeral director, page 5 should be detached for 7grade nentary/Secondary (0-12) College (1-4 or 5 +) Domestic Work House Keeper 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Edward Long Quinn to Leah BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1805 CYPRESS RD., POCOMOKE, MD. 21851 ELMER SMITH e METHOD OF DISPOSITION
Burlel 2 Cremation 3 Removal from State 20g METHOD OF DISPOSITION
1 Disposition 3 Red
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Cem. Union ville Percomoke City. Ma. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITYP 0. BOX46 3812 Davis R. Savage Funeral Home filled in by the 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one ceuse on such line. New Church. Va. 23415 medical Approximate 6 IMMEDIATE CAUSE (Finei Onset and Death the disesse or condition_ IND Stars RENAU DISEASE completely 214R resulting in death) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): and com o burial, GI BLEGDIN Q. 1 Pay CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if eny, leeding to immediate cause. Enter UNDERLYING HTN 20 YE. CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 8 4R. CV 4. signed by the atter Health and Mental PART ii. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? CMF, 1 YES 2 NO Shows 1 | YES 2 | NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN certificate has be h the State Dept. d, or Item 23 s 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: DR ATTENDING PHYSICIAN: 1 YES 1 NO Impetiant 2 - ER/Outpatient 3 - DOA 4 Nursing Name 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCUREO marked, with this Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation DIRECTOR: Aft hours after de: Item 28 is n 3 Suicide 26e. PLACE OF INJURY — Al home, ferm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide COMPLET 29e. CERTIFIER

(Chark only CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL I within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data end piece, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IS 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Cealsh boundry MD D32014 418/95 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAHBH MOONDRA S47 E LIVERSIDEDRIVE SALISBURY MD 2/801 8 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

STATE REGISTRAR

31. DATE FILED (Month, Day, Year)

APR 21 1995

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	2
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Schaufert Richard YEAR APRIL 729 1995 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)
8 - 29 - 19 6. AGE (In vrs. lest birthday 8. BIRTHPLACE (State or Foreign 215-14-494 1 M 2 | F O Pensylvania Should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Pages 1, 2, RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland
100. STREET AND NUMBER Station Somerset 1 YES 2 NO permit. FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4719 21838 burial-transit MOAC 11 MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced white the SE COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 18e, DECEOENT'S USUAL OCCUPATION use 16b. KIND OF BUSINESS/INDUSTRY jo ntary/Secondary (0-12) College (1-4 or 5+) 12 Machinest detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, 9 to Hmanda BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City S 2 Kathryn Marion Station, Md 21838 9 20a, METHOD OF DISPOSITION
1 M Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or must Pocomoke 4 Donation 5 Other (Specify) or other traumatic event, the medical examiner 21. SHUNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MELSON FUNERAL H Nelso PO Box 64, Pocomoke City the 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, la by Approximata shock, or haart failure. List only one cause on each line. 0 Interval Between filled **IMMEDIATE CAUSE (Final** Onset and Death cremation. disease or condition___ ARREST completely resulting in death) and com CERTIFICATION 21418 Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) attending physician a ntal Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and by AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? signed t 1 TYES 2 AT NO 1 YES 2 NO been of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State **EXAMINER?** HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA 1 YES 2 NO OTHER: 4 Nursing Home 5 Realdence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this owith 1 Natural 5 Pending Investigation 1 YES 2 NO ВУ After 2 Accident .00 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: J 28 4 Homicide Item 29a. CERTIFIER 1 DETIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(a) end menner as stated. FUNERAL I = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXA on and/or investigation, in my opinion, desth occured at the time, data and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sc 55/ Craig . Md. 2180 8 31. DATE FILED (MONTH, Day, Year)
APR 2 1 1995 32. REGISTRAR'S SIGNATURE

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after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH Sin race В 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS 77 1 1 M 2 M HOURS 190-12-3430 August Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Mercy Medical Center Baltimore <u>Baltimore</u> RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Westminster permit. MD 1 YES 2 NO Carroll FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1510 E.Mayberry Rd. use as the burial-transit 21158 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuben, Maxican, Puerto Rican, etc.) 1 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life, Do NOT use refined.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 United Telephone Once. 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Horace Schue ₩ Sarah Phillips notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John J.Stuffle 510 E. Mayberry Rd. Westminster, MD21158 be 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata OATE examiner must Haven Cemetery Hanover PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Littles'F.H.34 Maple Ave.Littlestown,PA filled in by the fion, or removal, medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata ahock, or haart failure. List only ona cause on each iine. interval Batween IMMEDIATE CAUSE (Final Onset and Death cremation, the disease Dr condition ______
reaulting in death) Sleeding the attending physician and completely is Mental Hygiene prior to burial, cremation event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditiona, **OUE TO (OR AS A CONSEQUENCE** If any, leading to immediate DR ATTENDING PHYSICIAN: The law requires that the death certificate be e DIRECTOR: After this certificate has been signed by the attending physician hours after death with the State Dept, of Health and Mental Hygiene prior to item 28 is marked, or item 23 shows any injury, or other traum cause. Enter UNDERLYING CAUSE (Diseasa or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Levcoponi PERFORMEO? AVAILABLE PRIDE TO COMPLETION DF CAUSE DF DEATH? 1 WES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 5 Residence 6 Other (Specify) 4 - Nursing Home 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF Natural 28d. OEŞCRIBE HOW INJURY OCCURED 5 Pending 1 YES 2 NO BY Investigation Accident 28e. PLACE OF INJURY — At home, farm, streef, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manual control of the cause (b) and manual control of the cause (c) and control of the control of t TO THE HOSPITAL D
TO THE FUNERAL DI
BE filed within 72 ho
IMPORTANT: If Its (Check only one) 2 MEDICAL EXAMINER: On the beale of examination end/or investigation, in my opinion, death occurred at the fir + Truchi 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d, DATE SIGNEO (Month, Day 8 9

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32. REGISTRAR'S SIGNATURE

MARVIN

31. DATE FILED (Month, Day,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DSPITAL OR ATTENDING PHYSIC	INERAL DIRECTOR: After this ce	thin 72 hours after death with t	INT: If item 28 Is marked,
TO THE H	TO THE F	be filed w	IMPORT

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

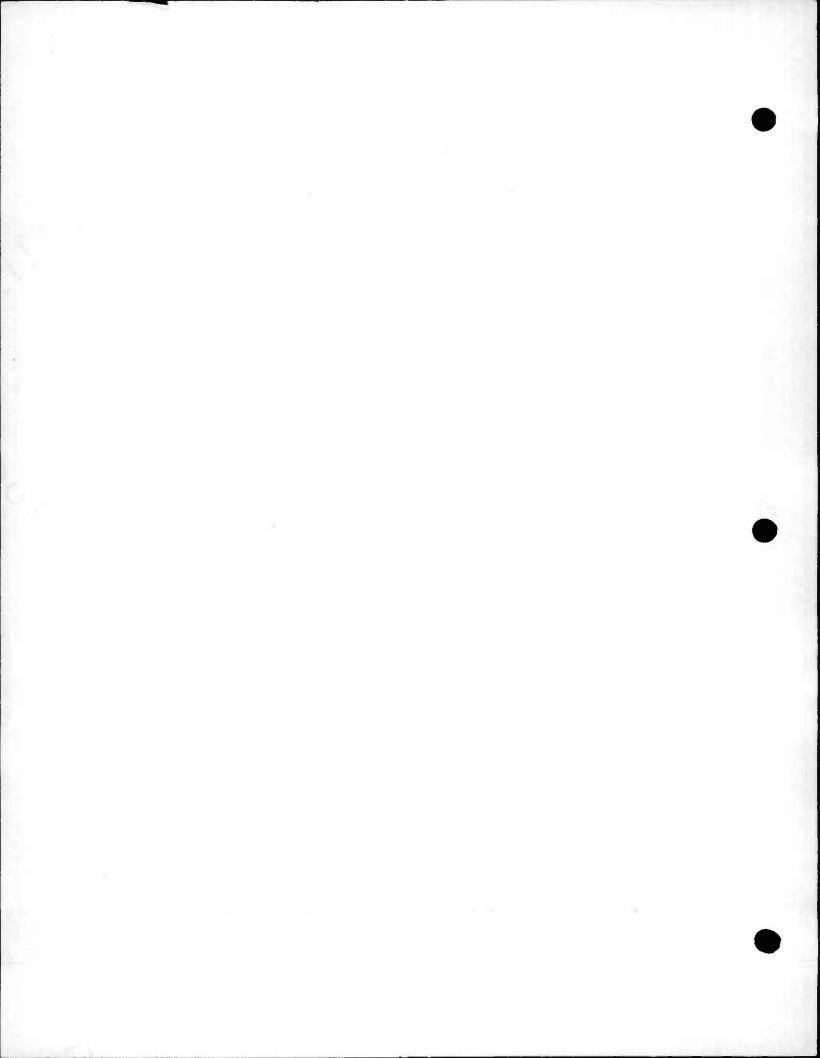
notified at pe must examiner medical the event. traumatic or other injury, 23 shows any

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Micidle Lest) 2. DATE OF DEATH 3. TIME OF DEATH EDWARD SHEETS April 1995 3:55 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS 1 7 M 2 | F 578-09-4967 80 Mar. 7, 1915 North Carolina 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Doctors Community Hospital Lanham, MD Prince Georges RESIDENCE OF DECEDER 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Lanham 1 - YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9305 Alcona Street 20706 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 TES 2 NO Specify: ВУ 3 X Widowed 4 Olvorced White 16a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Furniture Salesman Furniture Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Sheets 띪 Lillian (Unknown) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 20a. METHOD OF DISPOSITION
1 Burlal 2 Cremation
4 Donation <u>Kathleen G. Houser</u> 3008 Cedar Way, Upper Marlboro, Maryland 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, Stata DATE Burial 2 Cremation 3 Re Fort Lincoln Cemetery Donation 8 Other (Specify) 4/6/95 Brentwood, Maryland 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Wack Fort Lincoln Funeral Home, Inc. uch 3401 Bladensburg Rd., Brentwood, MD 20722 23. PART I. Entar the diseases, or complications thet causes the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition reaulting in death) PUT TO (ON AS A CONSEQUENCE OF): 10 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 40 CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural Pending Investigation BY 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated, the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: Or 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H April 3, 1995 D31528 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Rochells

Landover Road, Cheverly, MD 20785



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THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exproved feeth. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

TO BE COMPLETED BY FUNERAL DIRECTOR

								95		3621
FOR STATE REGISTRAR	TATE OF MARYL	AND / DEPA CERTII	RTM FIC/	ENT OF	HEALTH AND	MENTAI	HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH			3. TIME OF DEATH
James SMITH						Apr	l 8, °	1995	YEAR	12:45 A. M
4. SOCIAL SECURITY NUMBER 5. SE	EX 6. AGE	(In yrs. lest birthday		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		a. BIRTH	IPLACE (State or Foreign
209-05-0557	M 2 🗌 F	86 YRS.	MON	THS DAYS	HOURS MIN.			909		m nsylvania
9a. FACILITY NAME (If not institution, give street an	d number)		96.	CITY, TOWN	OR LOCATION OF DI		10,		INTY OF D	
Doctors Community H	lospital		L	anham				Pri	nce	Georges
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		Lucia							1	
	Coomesta	10c. C		WN OR LOCA	-					10d. INSIDE CITY LIMITS?
Maryland Prince	George s		G	reenbe						1 X YES 2 NO
				10	of. ZIP CODE			22		WHAT COUNTRY?
19 F Ridge Road					20770				.S.A	•
1 Never Married 2 Merried F	WAS DECEDENT EVER I ORCES? 1 YES	2 X NO			CENDENT OF HISPAI pecify Cuben, Mexica			or No-	14. RACE Black	E — Americen Indian, k, White, etc.
3 ☑ Widowed 4 ☐ Divorced	YES, GIVE WAR OR D	ATES		1 🗆 YE	S 2 🔀 NO Specif	γ:			Speci	w. White
15. OECEDENT'S EDUCATION	1	16s. DECEDENT	s usu	AL OCCUPAT	ON	166	KIND OF BUS	UNESS/IN	OUSTRY	WIIILE
(Specify only highest grade complete Elementary/Secondary (0-12) Coll	eted) ege (1-4 or 5 +)	(Give kind o life. Do NOT	work o	done during m ired.)	ost of working					
12		Chief o	f P	lant	Maintenance	e U	.S. Go	verr	ment	
17. FATHER'S NAME (First, Middle, Last)										
Thomas Smith										
19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADO	PRESS (Street	end Number or Rural	Route Numb	er, City or Tow	n, State, Zij	p Code)	
Stephen J. Smith		P.O.	Воз	x 544,	North B	each,	Mary	land	207	714
20e. METHOD OF DISPOSITION 1 🗵 Burlel 2 🗆 Cremetion 3 🗀 Removal fr	201	. PLACE AND DATE	OFD	SPOSITION /A	lame of	DATI	20c. LO	CATION —	City or To	wn, State
4 Donation 5 Other (Specify)	G.	ate of H	other p	ven Ce	m. 4/1	2/95	Sil	ver :	Spri	ng, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME A	ND AOORESS OF FA	CILITY		-		-
	١.				is Gasch'					
23. PART i. Enter the diseases, or compli	cesson that cause	d the death. Do	not a	4/39	Baltimore	e Ave	.,Hyat	tsvi	LIIe,	MD 20781
ahock, or heart failure. List o	nly one cause on e	each line.	HOL E	mer the m	ode of dying, auc	n am cerc	iac or respi	ratory ar	rest,	Approximate interval Between
iMMEDIATE CAUSE (Final disease or condition	Preva									Onset and Death
resulting in death) a										
	DUE TO (OH AS	A CONSEQUENCE	OF):							
Sequentially list conditions, b.	DUE TO (OR AS	A CONSEQUENCE	OE)							
if any, leading to immediate cause. Enter UNDERLYING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		/-							İ
CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):										
reaulting in death) LAST										
d										
PART ii. Other aignificent conditions con	1	1			ng cause given in	Part i.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Parkinsonism,	Lemen	414, 1E	-11	1010	us Ane.	419,	1 TYES 2			COMPLETION OF CAUSE OF DEATH?
Hxpe-tension	Rangi	Ins	, f.	fre i'e	L MCY.			_		1 TYES 2 THO
DID TOBACCO USE CONTRIBU	TE TO CAUSE C	OF DEATH Y	ES [] NO [UNCERTAI	N 🗆				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	201741	26. PLACE OF DE)					
	SPITAL: Inpatient 2 - ER/Out	patient 3 🗆 DOA		HER: Numing Ho	me 5 - Reeldence	8 Other	(Specify)			

27. MANNER OF DEATH 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural
2 Accident
3 Suicide 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner ee stated.

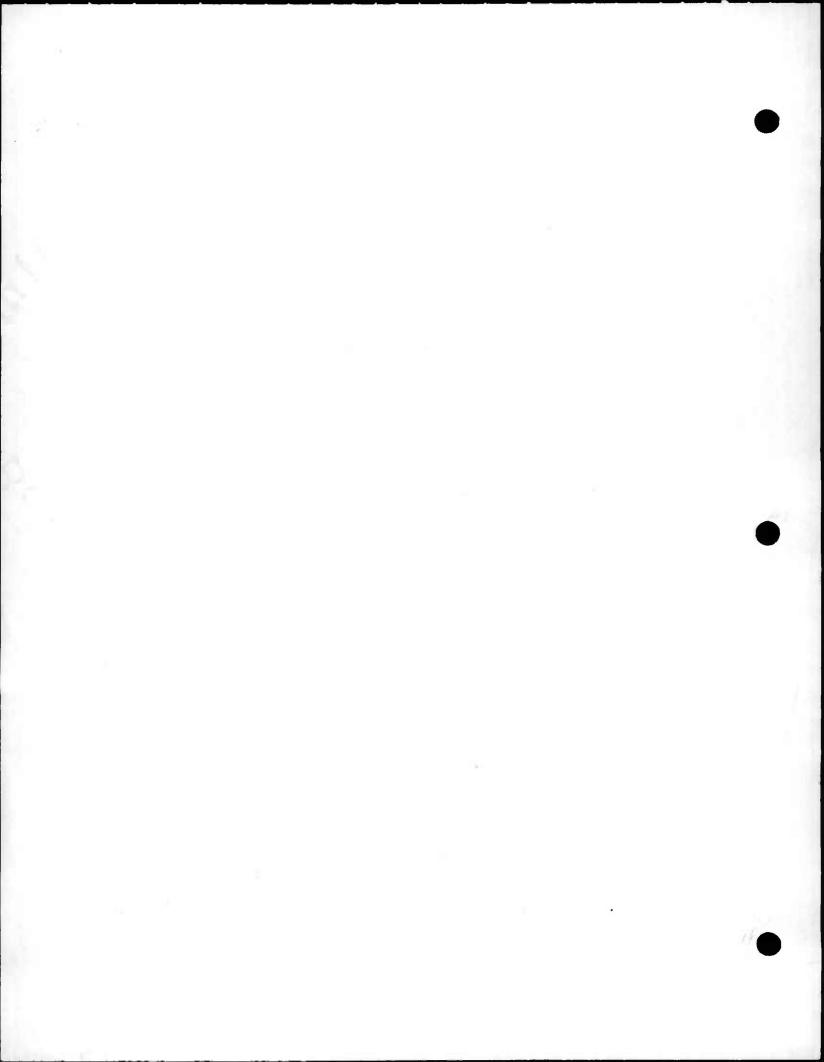
29c. LICENSE NUMBER D31001

WHO COMPLETED DOOS! OF DEATH (ITEM 27) (Type, Print)

7500 Greenbelt Center Drive #430 Greenbelt, MD Stuart Turkewitz. MD 20770 32. REGISTRAR'S SIGNATURE

APP I 0 1905

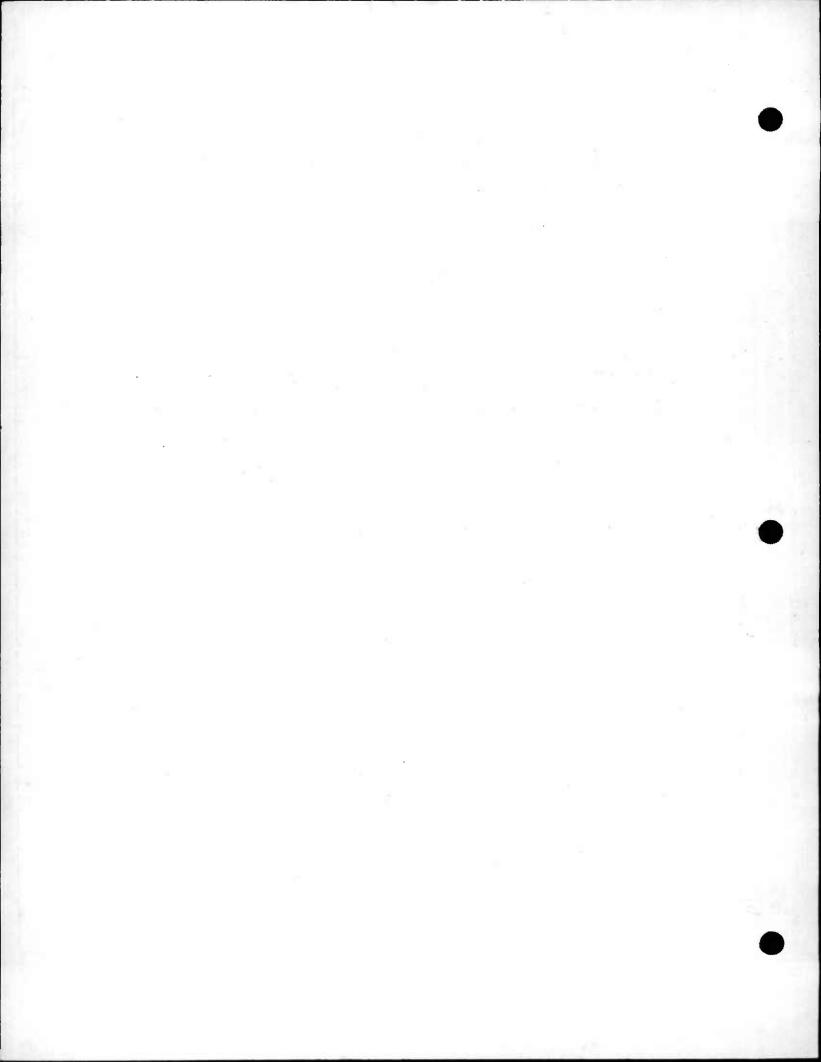
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

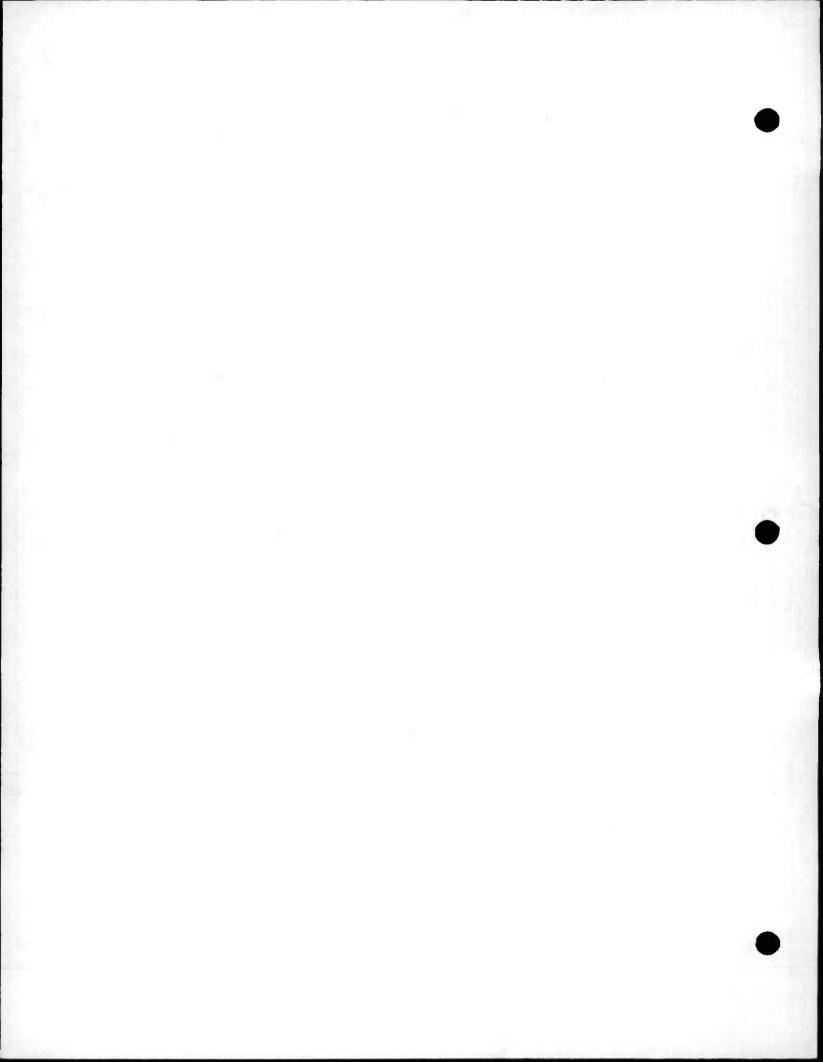
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR state this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal. IMPORTANT: it liem 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR		STATE OF I	MARYLAND	DEPAR	RTMENT	OF H	EALTH	AND	MENT					
	1. DECEDENT'S NAME (First	Miridle Leet			CERTIF	ICATE	OF	DEA	IH	1	REG. NO),			
	,	Widdia, Dasty	**			a 1				MOI		AY	YEAR	3. TIME OF	
	Elba 4. SOCIAL SECURITY NUMBER 4. SOCIAL SEC	FD	Yanir		lest birthdev)	Sancl				-		08 1	995	195	
		-Cn	1 M 2 F		YRS.	-	DAYS	HOURS	MIN.	7. DAT	E OF BIRTN oth, Day, Year)		S. BIRT	NPLACE (State try)	or Foreign
	212-33-0650	40. 41. 4		22	THS.				1	1 23	72		SALVAI	OOR	
œ	9a. FACILITY NAME (If not in					9b. CITY, T	TOWN O	R LOCATI	ON OF D	EATH		9c. CO	UNTY OF	DEATN	
DIRECTOR	9737 Mour	nt Pis	sgah Ro	ad		S:	ilv	er	Spr	ing		Mc	ntg	omery	
E	10a. STATE	10b. COUNTY			10c, CI1	Y, TOWN OR	LOCATI	ION						10d, INSIDE	OWN
Ë	MD	MONTH	COMBBY											LIMITS	?
	10e. STREET AND NUMBER	MONT	GOMERY		1 51	LVER		ZIP COD	-			1		TX YES	
F	0727 201720	DIGGO	77 DOID									-			HY7
FUNERAL	9737 MOUNT	PISGA	12. WAS DECEDEN		ADMED	40.110		0904				EL S	SALV		
	1X Never Married 2	Married	FORCES? 1	YES 2	X NO	IL)	yes, spe	cify Cubi	in, Maxica	en, Puert	ilN7 (Specify Yes o Rican, etc.)	s or No—	14. RAC Blac	E — Americar ck, White, atc.	Indian,
ВҰ	3 Widowed 4 Divo	rced	IF YES, GIVE V	WAR OR DATES		1X	YES	2 NO	Specif	fy:			HT.	SPANIC	
G	15. DEC	EDENT'S EDUC	CATION	18a.	DECEDENT'S	USUAL OCC	UPATIO	N .		1	Sb. KIND OF BU	CINECC/IN		31711110	
	(Specify onl	highest grade	College (1-4 or 5		(Give kind of life. Do NOT u	work done dur	ring mos	t of worki	ng	- 1"	DO. KIND OF BO	SIVE 33/IN	ioo31H1		
7	8TH	,,	College (1-4 of 5		CASHIE	R				Tal	ENDY'S	DEC	י מוואים	MT	
COMPLETED	17. FATHER'S NAME (First, M	ddle, Last)					T	16. MOT	NER'S NA		, Middle, Maiden		IAUIO	71/1	
C	LUIS R. GAR	CIA							SI S			ourname)			
0	19a. INFORMANT'S NAME (7				19b. MAILING	ACORESS (Straet en				mber, City or Tow	on Ctute 7	In Codel		
5	LUIS R. GAR	CTA	(FATHER)								GELES,			2006	
1	20a. METHOD OF DISPOSIT		(IIIIIII)		CE AND DATE				LUS	7.0					
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 🗆 Remo	oval from Stata	cemetery,	cremetory or o	ther place	DT O	ne of		1	- 100			own, State	
i i	21. SIGNATURE OF FUNERA		ENSFF	_ 1FC	-DU 21				SS OF FA		8/95 M	ANCHI	STEI	R CLAP	E
1		211	0			W.H	. B.	ACON	FUN	VERA	L HOME	TNC.			
	w.	10-1	vaco	2/2	76						N.W. WA		-	20010	
	23. PART i. Enter the di	sesses, or c	omplicatione the	t ceused the	deeth. Do	not enter th	ne mod	le of dy	ing, suc	h 66 Ce	rdisc or respi	iratory a	rrest,		oximate
	snock, or no	shock, or heert fellure. List only one ceuee on each line. IMMEDIATE CAUSE (Final Onset and Deeth													
	diseese or condition		GUI	VS40	T /Al	MANE		AF	11	F.7)				and beath
	resulting in death)			(OR AS A CON				U	tT.	VA					
z														İ	
CERTIFICATION	Sequentielly list conditi if any, leading to imme-		DUE TO	(OR AS A CON	SEQUENCE O	F):								- 	
3	cause. Enter UNDERLYI	NG													
	CAUSE (Disease or inju that initiated events		DUE TO	(OR AS A CON	SEQUENCE O	F):									
2	resulting in death) LAS		ı												
5	DART II OHIIII														
¥	PART II. Other significa	nt conditions	s contributing to	deeth but no	t resulting	in the unde	erlying	ceuse (given in	Part I.	24a. WAS AN PERFOR	AUTOPSY	248	WERE AUTOP	
5											1 YES 2	□ NO		OF DEATH?	
E I											/~			1 YES 2	□ NO
ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DI	EATH YE	S 🗆 NO	0 🗆	UNC	ERTAI	N \square				/-	
5	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:	26. PL	ACE OF DEAT		y one)								
2	1 X YES 2 NO		1 Inpetient 2	ER/Outpatient	3 DOA	OTHER:	g Home	5 X R	aldence	6 🗆 Ott	ner (Specify)				
PHYSICIAN: MEDICA	27. MANNER OF DEATH		28a. DATE OF		26b. TIM	E OF 28	Bc. INJU WOR	RY AT			ESCRIBE NOW I	NJURY OC	CURED		
<u> </u>		ending reatigation	14/0/90	FAULTO	1880		1 YE	-	NO	31	MEJECT	SLH	OT		
	28e DIACE OF IN HIPV. As hands Total and the second of the								AAT						
COMPLEIED															
ונ	29a. CERTIFIER 1 CERT	EYING PHYSIC	TAN: To the heet of	my knowledge	double account	4 44 45 45							56A	1 5100	4041-
1	(Check only one) 2X MEDI	CAL EXAMINER	CIAN: To the best of R: On the beals of or	mination and/	or investigation	o to my onto	o, data a	eth occur	and due	to the c	luse(a) and mar	nner aa ats	ited,		
			NA AA		1	, my opin	_				a aru piace, an	u que to t	ria ceuse(, and manner	es stated.
	96) SGRATURE AND TITLE	UR WETTER	Now!	11	. /			29c. LICE	NSE NUN	MBER		29d. DAT	E SIGNED	(Month, Day,	Yoar)
		/	one.	111	WI			0.	C.M	.E.		Ar	ril	09 1	995
		-	7		Name and Address of the Owner, where										223
	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	H OF BEATH (I						_					
TO BE	30. NAME AND ADDRESS OF WAR 10 F	GOL	A 32. REGISTRA	R'S SIGNATURE	111 P		Str	eet	. В	alt	imore				



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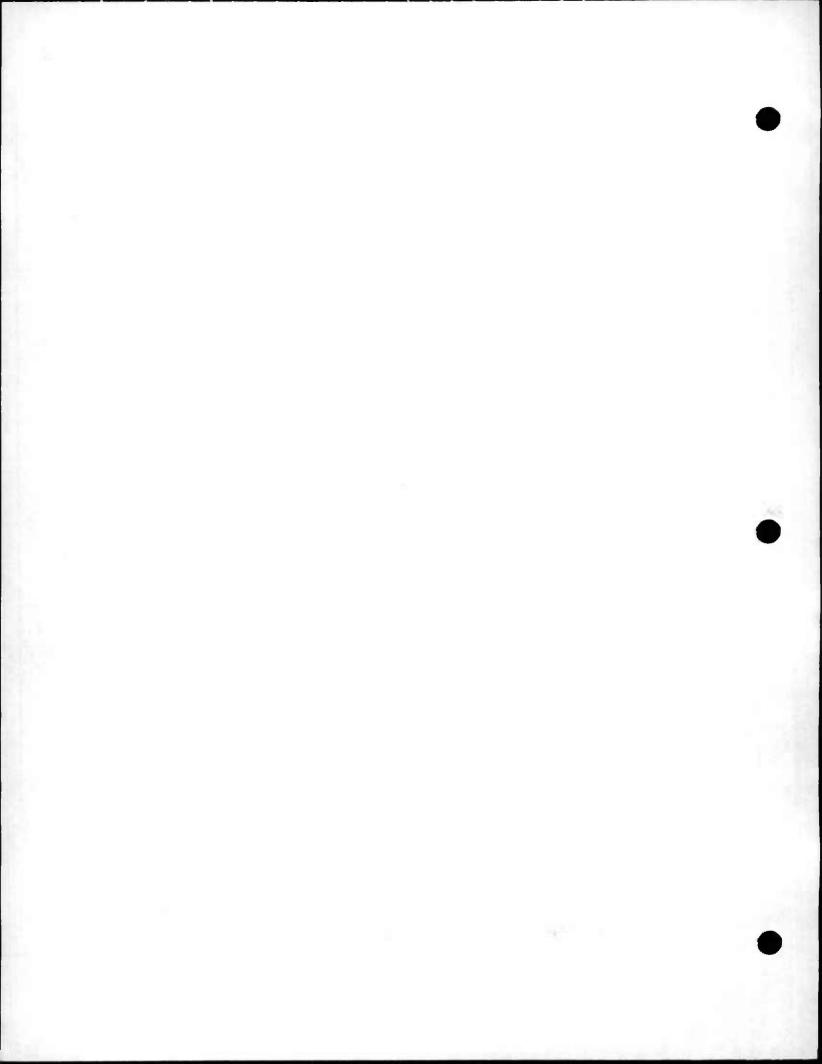
	_	REGISTRAR		CERTIF	ICATE O	F DEATH		REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)	D SM	ITH			MONTH	OF OEATH DA	NY O	EAR 3.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER			1 Color 10		APRIC		190		3:30 p
3 should		4. SOCIAL SECONITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEA			Day, Year)		Country)	ACE (State or Foreign
		578-52-3704	1 M 2 F	56 YRS.		V	Octo	ber 4,	1938	Washi	ington, D.C.
	l cc	9e. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUNTY		
5	DIRECTOR	Prince George's Hospital Cheverly PRINCE GEO									tokut S
permit. Pages 1.	Si Si	THE SIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION								10	Id. INSIDE CITY
<u>~</u>	8	District of Colu	mbia		V		1				LIMITS? YES 2 NO
ermi	A	10e. STREET AND NUMBER			101. ZIP CODE			10g. CITIZEI		T COUNTRY?	
- FS	EB.	4302 Gorman Te	rrace, S.E.			2001	9		Uni	ted	States
ptrysician. burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS [DECENOENT OF HISPA	NIC ORIGIN?	(Specify Yea			American Indian, /hite, etc.
ending as the	ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES			specify Cuban, Maxic rES 2 X NO Speci		ican, atc.)		Black, W Specify:	/hite, etc.
		3 Widowed 4 Divorced									Black
- 3	ETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S (Give kind of	work done during	ATION most of working	18b.	KIND OF BUS	SINESS/INDUS	TRY	
4 2 E	1	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u					27 / 4		
the hospital detached fo	COMPL	12th			None				N/A		
	- 1	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	_				
	H	James Clomax 19a. INFORMANT'S NAME (Type/Print)							e Cook		
retained 5 should notified	입					et and Number or Flural					.10
. 4 8 0		Roscoe Barnes 200. METHOD OF DISPOSITION				Terrace,					
for.	18	1 Suriel 2 ☐ Cremation 3 ☐ Rem	ovel from State 20t	netery, crematory or darmony Mem	OF DISPOSITION	(Name of	DATE	1	CATION — City		
	- 8	21. SIGNATURE OF FUNERAL SERVICE LIC		armony mem	-	TK AND ADORESS OF FA	4/15/95		Landove		
death. Pag tuneral di examiner	1 1	Stewart Funeral 4001 Benning Rd., N.E. Wash., D.C.									
after de by the fi moval.		John	Deword I								20019
		23. PART LEnter the disease, or of the street failure.	complications that cause List only one cause on a	d the death. Do	not enter the	mode of dying, euc	ch ee cardi	ec or reepi	ratory arreal	ig	Approximate
		IMMEDIATE CAUSE (Final									Onset and Deati
		disease or condition resulting in death)	. Acute	Mudcar	idial.	Infanct					momente
Da 10 1			OUE TO (OR AS A	A CONSTQUENCE O	F):						
e be executed sician and con rrior to burial, traumatic ex	S O	disease or condition									
rite be exprictan a prior to	CATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events out to (or as a consequence of):									
Phy phy	윤	CAUSE (Disease or injury that initieted events	DUIL TO (OR AS A	F):						-	
000	RTIF	resulting in death) LAST									j
the atten Mental ?	빙										
=	EDICAL	PART II. Other significant condition	s contributing to death b	out not resulting	in the underly	ring ceuse given in	Part i.	24a. WAS AN			RE AUTOPSY FINDINGS
a the	음							1 YES 2		CO	MPLETION OF CAUSE
requires been sign of Hea	M										YES 2 NO
PHYSICIAN: The law requirents this certificate has been so he with the State Dept. of Harked, or Item 23 show	PHYSICIAN: M	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YE	S 🗆 NO	☐ UNCERTAI	N 🗆				
The ate Date Dem	S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only or OTHER:	ne)					
cran: ertifica he St	YSI	1 TES 2 NO	1 Inpatient 2 ER/Outs	petient 3 XDOA	4 Nursing H	ome 5 🗆 Rasidence	8 XOther	(Specify) D	URING 1	4 WAL	KOUTSIDE
NG PHYSI fter this co eath with t		27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	26b. TIM	IURY	INJURY AT WORK?	28d. DESC	RIBE HOW I	JURY OCCUR	ED	
DING PHYS After this c death with	В	2 Accident Investigation				YES 2 NO					
ATTENDING PHYSICIAN: The law requirections: After this certificate has been a after death with the State Dept. of 128 is marked, or item 23 sho	G	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, term, soify)	street, factory, of	ffice	28t, LOCAT City or	TION (Street a Town, State)	nd Number or i	Pural Ploute	n Number,
DIRECTOR POUR ATTERNATE PROURS Aftern 28	H										
HOSPITAL OR ATTENDING FUNERAL DIRECTOR: After within 72 hours after death	COMPLETED	29a. CERTIFIER (Check only one)	CIAN: To the best of my know	ledge, death occum	ed at the time, d	eta and place, and due	to the cause	e(a) and man	ner es atated.		
JNER INT:	ŏ	2 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigation	n, in my opinion	n, death occured at the	time, date a	nd place, and	d due to the co	Juse(e) an	d manner as stated.
HE HE PE PE WINDE	ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER		29d. DATE SI	GNED (Mc	onth, Day, Year)
TO THE HOSPITAL (TO THE FUNERAL DE filed within 72 h	TO B		DME			D259	25		► Apr	27,	1995
1	-	30. NAME AND ADDRESS OF PERSON WHO	April 1			00	a		, -		
5				WISCONS	n ave	- Delk	escla	, m.	1 2	281	4
	Ì	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	Achala							



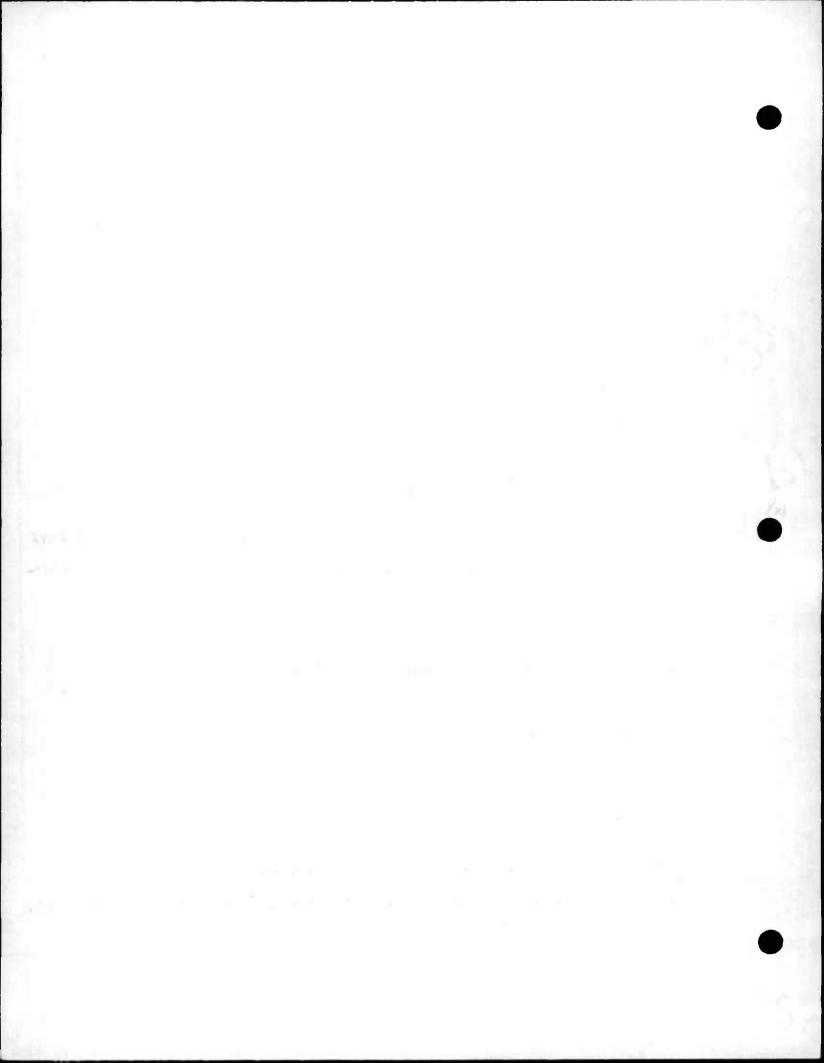
DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospit	
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31. DATE FILEO (Month, Day, Year)
APR 2 4 1995

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAI CERTIF	RTMENT OF H	HEALTH AND	MENTAL HYGIE				
		1. DECEDENT'S NAME (First, Middle, Lest)			1011.		2. DATE OF DEATH		3. TIME OF DEATH		
	Ü	Evelyn Virg	inia _{Shaff}				April 2	2, 1995	EAR		
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (H	In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. OATE OF BIRTH	8.	BIRTHPLACE (State or Foreign		
2		215-14-2596	1 D M 2 X F 79	9 YRS.	MONTHS DAYS	HOURS MIN.	Nov. 30	1915	Country) Marriand		
3 should	_	9a. FACILITY NAME (If not institution, give stre	eet and number)		96. CITY, TOWN	OR LOCATION OF D		9c. COUNTY	Maryland of DEATH		
1, 2, 3	ECTOR	Frederick Memorial Hospital Frederick Frederick RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 1000 OB LOCATION									
020 physician. burlat-transit permit. Pages 1, 2.	E I	Maryland Freder		10c. CIT	TY, TOWN OR LOCAT	TION	Knoxville	9	10d. INSIDE CITY LIMITS? 1 TYES 2 TO NO		
Decu	¥ F	10e. STREET AND NUMBER			10	of. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
an. ransit	FUNERAL	2559 Point of Roc				2175	8	U.3	S.A.		
20 nysicia	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS OED	CENOENT OF HISPA	ANIC ORIGIN? (Specify ten, Puerlo Rican, atc.)		RACE — American Indian, Black, White, atc.		
5-0020 nding physic is the burial	BY	3 Widowed 4 Divorced	ATES X		S 2 NO Speci			Specify: White			
	ED I	A 15. DECEOENT'S EDUCA	ATION	44- DECEDENT'S			144 41110 05 6				
	ETE	(Specify only highest grade of	completed)	mpleted) (Give kind of work done during most of work			16b. KIND OF E	USINESS/INOUS	TRY		
ND 2 hospital rached to	7	Elementary/Secondary (0-12)	College (1-4 or 5+)		Homemakei	r		Oran	n Home		
YLAND 2 by the hospital or be detached for at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			10illellane		AME (First, Middle, Maid		1 nome		
		awrence Alvin Pear:	1				erine Lapo				
S 88 20	00	19a. INFORMANT'S NAME (Type/Print)	L	T 19b. MAILING	ADDRESS (Street 1		Route Number, City or To		4.1		
5 5	2	Wayne V. Shaff					e, Salisbu				
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSITION	20b.		OF DISPOSITION (Na			LOCATION - City			
ORE e 6 may ector, pa		1 Duriel 2 Cremetion 3 Removed Topical Property Constitution 5 Other (Specify)	val from State come	etery, cremetory or o	other plece)						
Page al dire		21. SIGNATURE OF TUNERAL SERVICE LICE	INSEE SUL I	Mark's (Cemetery 22. NAME AN	ND ADDRESS OF FA	26, 199 ^s	Peter	csville, Md.		
ALTIN death. Pag funeral di		*Xubard C.	P Barbara	1			asford Fur	oral Ho	omo		
9 = 9	-	23. PART I. Enter the diseasea, or co		20001							
hours after to in by th or remove		23. PAHI I. Enter the diseasea, or co shock, or heart fellure. L	omplications thet caused lat only one cause on ee	the daeth. Do r och lina.	not anter the mo	ida of dying, suc	ch as cerdlec of res	piratory arrest	Approximate Interval Batween		
		IMMEDIATE CAUSE (Final	0						Oneat and Death		
>= =		disease or condition resulting in death)	Sepsi	2					dus		
Pa pa pa			OUE TO OR AS A		F):		Left	,	1/		
OX 687 e be executed sician and cor rior to burial, traumatic e	ON	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):									
OX OX be es lician a rior to	AT	If any, leading to immediate cause. Enter UNDERLYING	11100/10								
O. B. ertificate ing physical program of the transfer of the t	음』	CAUSE (Disease or injury that initiated events	DUE TO OFF AS A	CONSEQUENCE OF	D 1	05-6	pream	Olla	weeks.		
P.O. h certing anding Hygies	CERTIFICATION	resulting in death) LAST	LINE	neonla	1 00		1.000				
		u.			Tong				MAKE.		
F = 20 =	¥ I	PART II. Other algnificent conditions	contributing to death bu	. /		g cause given in		IN AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS		
O = 8 = 8	MEDIC/	Gall Stover	billary	Stasu	2		1 [] YES		AMILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH?		
PEC requires seen sign of Heal	W							1	1 YES 2 NO		
AL RE e faw requestres been Dept. of 123 sho	ż	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S NO X	UNCERTAIL	N 🗆				
VITAL JAN: The law rifficate has lee State Dept or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEAT	TH (Check only one)						
PHYSICIAN: The this certificate with the State	YS.	1 YES 2 NO	1 npetient 2 - ER/Outpet	rtlent 3 🗆 DOA	OTHER: 4 Nursing Hom	ie 5 🗆 Rasidenca	8 Other (Specify)				
OF PHYSIC this cer with th	표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED		
~ ~ ~ ~	À	1 X Natural 5 Pending 2 Accident Investigation				YES 2 NO					
VISION ATTENDING ECTOR: After s after death	8	3 Suicide & Could not be 4 Homicide determined	28s. PLACE OF INJURY - building, etc. (Specify	- At home, term, a	street, factory, office	8	281. LOCATION (Stree City or Town, Stat	t and Number or F	iural Route Number,		
DIVISION OR ATTENDING R DIRECTOR: After hours after death Item 28 is mar		4 Homicide datarmined									
DIV L OR A L DIREC	3 1	29a. CERTIFIER 1 CERTIFYING PHYSICI.	IAN: To the best of my knowled	idge, death occurre	ed at the time, data	and place, and due	a to the cause(a) and m	anner sa stated.			
HOSPITAL FUNERAL WITHIN 72 I	COMPL		On the besis of examination						use(s) and manner as stated.		
		29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			GNED (Month, Day, Year)		
	H C	MA				730	((3	D 4/	22/01		
	2	30. NAME AND ADDRESS OF PERSON WIND	COMPLETED CAUSE ON OEA	TH (ITEM 27) (Type,	, Print)	753	()	1	00.12		
		J.P. Henry	610 9th	Ave	Rec	UNIU CK	k mb	217	16		
_		31. DATE FILEO (Month, Dey, Year)	32. RIPGISTRAMS SIGNAT	TURE	. /		1				
	_ #	APR 2 4 1995	0	an a nacond	•						

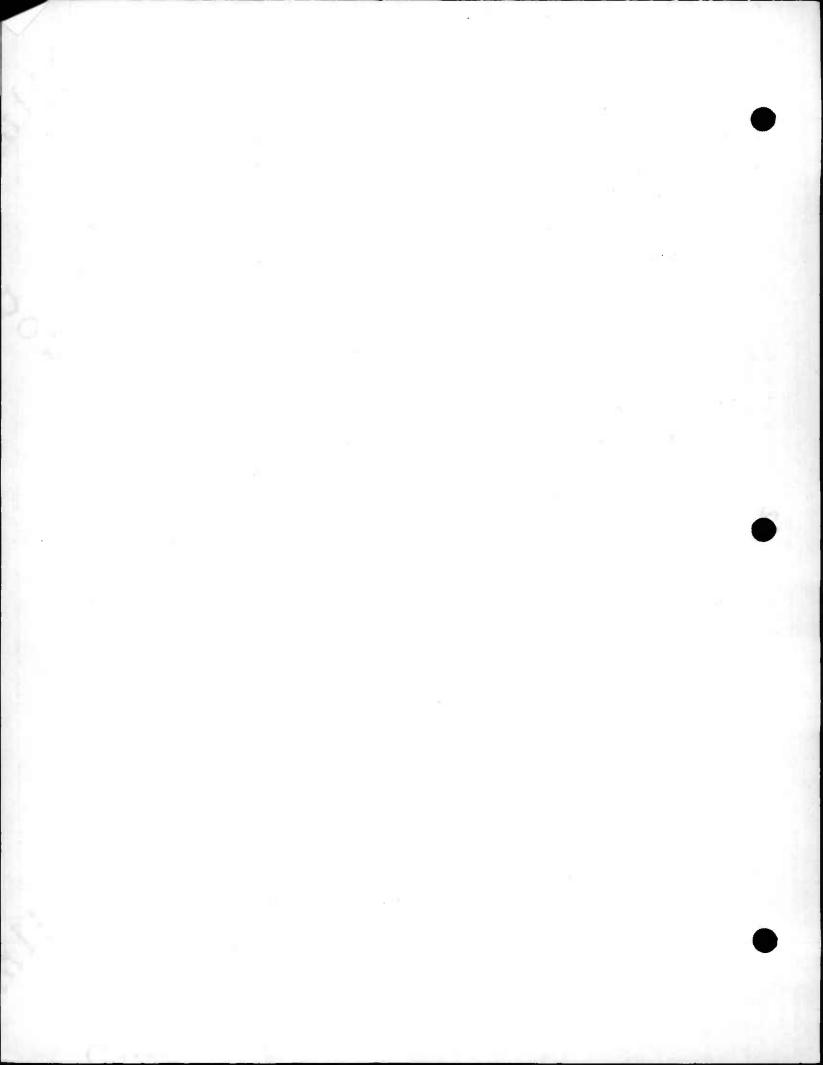


		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND		YGIENE EG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH	YEAR 3.	TIME OF DEATH
		Diana 4. SOCIAL SECURITY NUMBER	Saul			·	Apr	il 21, 10	95	5:42 A M
			5. SEX 6. AGE	(In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day	(Year)	Country)	ACE (State or Foreign
3 should		99. FACILITY NAME (if not institution, give street and number) 90. FACILITY NAME (if not institution, give street and number)							Maine	
ςi.	DIRECTOR									
permit. Pages 1,		Maryland Frede	10c. CITY, TOWN OR LOCATION Tick Thurmont					10	d. INSIDE CITY LIMITS?	
	₹\	10e. STREET AND NUMBER			10	1. ZIP COOE		10g. CITIZE	N OF WHA	T COUNTRY?
ian, transit	FUNER	15 Sunny Close				21788		Unite	≥d S	tates
21215-0020 If or attending physician, for use as the burial-transit	ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR O	2 K NO	If yes, sp	CENDENT OF HISPA Hecify Cuban, Mexic 5 2 NO Speci	en, Puerto Rican,	ecify Yee or No— 1 , etc.)	4. RACE — Black, W Specify:	American Indian, hite, etc. White
215-0 attending use as the	LED	15. DECEDENT'S EDUCA (Specify only highest grade or	16a. DECEDENT'S	USUAL OCCUPATION WORK done during me	16b. KING	O OF BUSINESS/INOU	STRY	WILLE		
	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	III. Do NOI u	se retired.)					
AND 2 he hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	2	Residen	t Manage	7	-	artment Re	ental	
2 6 8 W	ECC	Maurice Wesley Gre	enlaw					Maiden Surneme) ce Anderso	nn n	
MAR retained 5 should notified	00	19a. INFORMANT'S NAME (Type/Print)	- CALLESTY	19b. MAILING	ADDRESS (Street o					
E, M Age 5 s Be mgt	5	Diana L. Beebe 1996. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co 6414 Greyfield Rd., Fayetteville, N.C							303	
H S H		20a. METHOD OF DISPOSITION 1 Surjet 2 N Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION —						20c. LOCATION — CH		
IMORE, Page 6 may be I director, page ner must be		4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE!		agerstow				Hagerstov	m, M	aryland
ALTIMO death. Page 6 t funeral directo c		-		0	Stauf	fer Fune	ral Hon	nes, P.A.		
× - = = -	_		s. Mac		104 E	. Main S	treet,	Thurmont,	, MD	21788
Xの音音を配		23. PART i. Enter tha diseases, or con shock, or heart fellure. Li	mplications that ceused at only one ceuse on a	d tha death, Do i ech line.	not enter tha mo	oda of dying, suc	ch as cardiac	or reapiratory arres	it,	Approximats interval Between
		iMMEDIATE CAUSE (Finei disesse or condition	0.000	9.0 (4.						Onset and Death
d within completely fille cremation, event, the		disease or condition resulting in death) s. CEREBRAL VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF):								5 DAYS
execute execute to buria	ERTIFICATION	Sequentially list conditions, our to (or as a consequence of): ATRIAL FIBRILLATION OUR TO (OR AS A CONSEQUENCE OF):								5 YEARS
ate be hysiciar prior	S	cause. Enter UNDERLYING CAUSE (Disease or injury								
th certificate ending physical Hygiene processor or other to	TE	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
J = 5 = 0	CER	resurring in deeth) LAS1								
宣言語		PART II. Other algnificent conditions				g ceuse given in		WAS AN AUTOPSY		RE AUTOPSY FINOINGS
L # 0 # >	MEDICAL	HEPATIC CIRI	2 HOSIS, 1	BLEAST	CANC	ER		PERFORMED?	CO	MABLE PRIOR TO MPLETION OF CAUSE DEATH?
requires the een signed of Health shows an										YES 2 NO
as bept.	SICIAN	DID TOBACCO USE CONTRI				UNCERTAI	N 🗆			
VIIAL AN: The lav inficate has state Dep	SICI	EXAMINER?	HOSPITAL:	26. PLACE OF OEA	OTHER:					
HYSICIA HIS Certif Mith the	PHY	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM	E OF 28c. INJ	URY AT		city) E HOW INJURY OCCUI	RED	
NG PHYS fter this eath with	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO				
TTENDI TTOR: A after da	ETED 8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	street, fectory, offic	•	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			Number,
- K K A A E	P.E.	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of my knowl	ledge, death occum	ed at the time, date	end placs, end due	lo lhe cause(s)	end menner es stated		
SPITAL VERAL Nin 72	COMPL	one) 2 MEDICAL EXAMINER:								d menner se stated,
TO THE HOSPITAL OF THE FUNERAL DE FIEM WITHIN 72 PORTANT: IF IN		29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				nth, Day, Yeer)
₩ ₩ ₩ ₩ ₩	38 C			, MD		0219	736	Þ 4.	21.	95
	5	30. NAME AND ADDRESS OF PERSON WHO O	DONELSO.	N 915	TOLL	-House	4203			K 21701
		31. DATE FILED (Month, Doy, Year) APR 2 4 1995	32. RECISTRAR'S SIGN	har Redell						



OR TATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
EGISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DAY	VEAD	3. TIME OF DEATH					
	H	James Robert Smith, Sr.		1995	5 • 15 a M					
_		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) # UNDER 1 YEAR # UNDER 24 HHS. 217-36-7044 1 M 2 F F F F F F UNDER 24 HHS. 7RS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Country						
3 should		9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF	LAug 11 19	30 Mar	y land					
1, 2,	СТОВ	12405 Hickory Tree Way Germantown Montgomery								
. Pages	DIRE	Md Montgomery Germantown		- 1	10d. INSIDE CITY LIMITS? 1 YES 2 NO					
permit.		104. STREET AND NUMBER 101. ZIP CODE	1	10g. CITIZEN OF W	1275					
St.	E	12405 Hickory Tree Way Apt D 2087	4	U.S	Δ					
21215-0020 or attending physician. Ir use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MONO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISP It yes, specify Cuben, Mexi 1 YES 2 NO Specific Company of the com	ANIC ORIGIN? (Specify Yee or can, Puerto Ricen, etc.)	r No- 14. RACE Black	,—American Indian, , white, etc.					
215 attend use as	9	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSIN							
D 21 pital or ad for u	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do NOT use retired.)			1, 1					
AND the hospit detached once.	MO	not employed	IAME (First, Middle, Maiden Sur	(mame)	-					
by the	BE C	Lee Smith Beaula	ah I. Nicho	ols						
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	10	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rure) Filing about by Comit by	i Route Number, City or Town, S	State, Zip Code)	20874					
ay be re page 5	-	Elizabeth Smith 12405 Hickory Tree	e Way Germa	antown	Md					
Page 6 may be director, page ner must be r		1 Buriel 2 Cremetion 3 Removal from State		TION — City or To						
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF	FACILITY	LISVIL	Le, Md.					
BALLIMOR after death. Page 6 ma by the funeral director, p moval.		Wm C Nult Hilton Fun Barnesvill		38						
S aff	175	 PART I. Enter the diseasea, or complications that caused the death. Do not anter the mode of dying, su shock, or heart fellure. List only one cause on each line. 			Approximate Interval Between					
		IMMEDIATE CAUSE (Final Onset and Death								
ted withis completely filk ial, cremation,		disease or condition resulting in death) . Mctastatic gastric gustric pue to (or as a consequence of):	Carame	ma	6 month					
2 5 5 6 E	z									
. 5 5	ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
ertificate be on physicia gliene prior other train	FIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
. 이 필요 느	ERTIFICATION	resulting in deeth) LAST								
t the death by the attended Mental injury, o	O	PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given it	n Part I. 24e. WAS AN AU	ITOBEY 24h	WERE AUTOPSY FINDINGS					
7 2 88 2 7	ICAL		PERFORME	ED?	AMILABLE PRIOR TO COMPLETION OF CAUSE					
requires that seen signed of Health shows an	MEDIC		t - YES 2 [5]	, NO	OF DEATH?					
> 10 er	N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO								
The The safe the Date to Date the Date to Date the Date to Date the Date th	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (0 EXAMINER? HOSPITAL: OTHER:	Check only one)							
SICIAN: The Certificate the State	PHYS	1 UPS 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 & Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 25b. TIME OF 28c. INJURY AT	6 Other (Specify) 26d. DESCRIBE HOW INJU	Hay coorings						
Red with PH C		1 Natural 5 Pending (Month, Day, Year) INJURY WORK?	200. DESCRIBE HOW INJU	JHY OCCURED						
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St Item 28 is marked, or it	red BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 23e. PLACE OF INJURY — At home, ferm, streel, factory, office building, atc. (Specify)	261, LOCATION (Street and City or Town, State)	Number or Rural R	oute Number,					
Te De Distriction	LET	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilms, date and place, and determined to the ilms.	to the the council and more	and the state of						
■ 28 ¥	COMPL	(Check only 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the ilme, date end piace, and discovered at the ilme, date end piace, and date			end menner ee stated.					
THE HOSP! THE FUNER filed within	BE C	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE N		29d. DATE SIGNED						
5 5 9 W	5	Thenow MD D3	3224	MARIL	24,1995					
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R TYCHOM MD SOW Edmundon De #40) 1, Rock	ville	up 20852					
		APR 25 1995 July d'Avelor Robert								



29a. CERTIFIER 1 X CERTIFYING PHYSICIAN:

30. NAME AND ADDRESS OF PERSON WHO COM ALAN CARROLL, M.D.,

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

BE 2 2 MEDICAL EXAMINER: 9

APR 2 1 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Sanders 20 A M eonard 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAY8 HOURS 1 X M 2 - F 215-32-5615 90 JUL Y 1904 FAIRFIEL D. PA 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. CATHERINE'S NURSING HOME **EMMITSBURG** FREDERICK 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND FREDERICK **EMMITSBURG** 1 - YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 17504 TRACT RD. 21727 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, alc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 8 POSTAL SERVICE CLERK notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) SAMUEL HILARY SANDERS CATHERINE BEARD BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN K. SANDERS 17504 TRACT RD., EMMITSBURG, MD. 21727 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1 Burial 2 X Cremation 3 Ra
4 Donation 5 Other (Specify) must SMITHSBURG CREMATORIUM SMITHSBURG, MD. 21783 H. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 medical 23. 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, abock, or heart failure. List only one cause on each line. Interval Retwe IMMEDIATE CAUSE (Final Onaat and Daath the disease or condition reaulting in death) event, CONSEQUENCE OF traumatic CERTIFICATION Sequantisly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PARTII. Other aigniticant conditions cor MEDICAL CL any DID TOBACCO USE CONTRIBU PHYSICIAN g 25. WAS CASE REFERRED TO MEDICAL 1 TES 2 X NO 9 27. MANNER OF DEATH marked, 1 X Natural 5 Pending Investigation BY 2 Accident 3 Sulcide ,69 COMPLETED 8 Could not be 4 Homicide 28

		4				
tributing to death but not in the second of	Locale	nderlying cause given in	ecto	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 🂢 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
	CE OF DEATH (Check	only one)				_
SPITAL: Inpatient 2 - ER/Oulpetient 3	□ DOA 4 12 Nu	R: rsing Home 5 - Residence	8 🗆 Other	(Specify)		-
28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d. DE\$0	RIBE HOW INJURY OCCU	RED	
26a. PLACE OF INJURY — AI ho building, atc. (Specify) To the best of my knowledge, de basis of axamination and/or	ath occurred at the	time, date and place, end du-	City or			_
la C	auc	29c. LICENSE NU			SIGNED (Month, Day, Year)	-
PLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)					-
310 S. SET	ON AVE.,	EMMITSBURG,	MD.	21727		
32. REGISTRAN'S SIGNATURE	Revall					
					DHMH-16 Rev 1/6	99

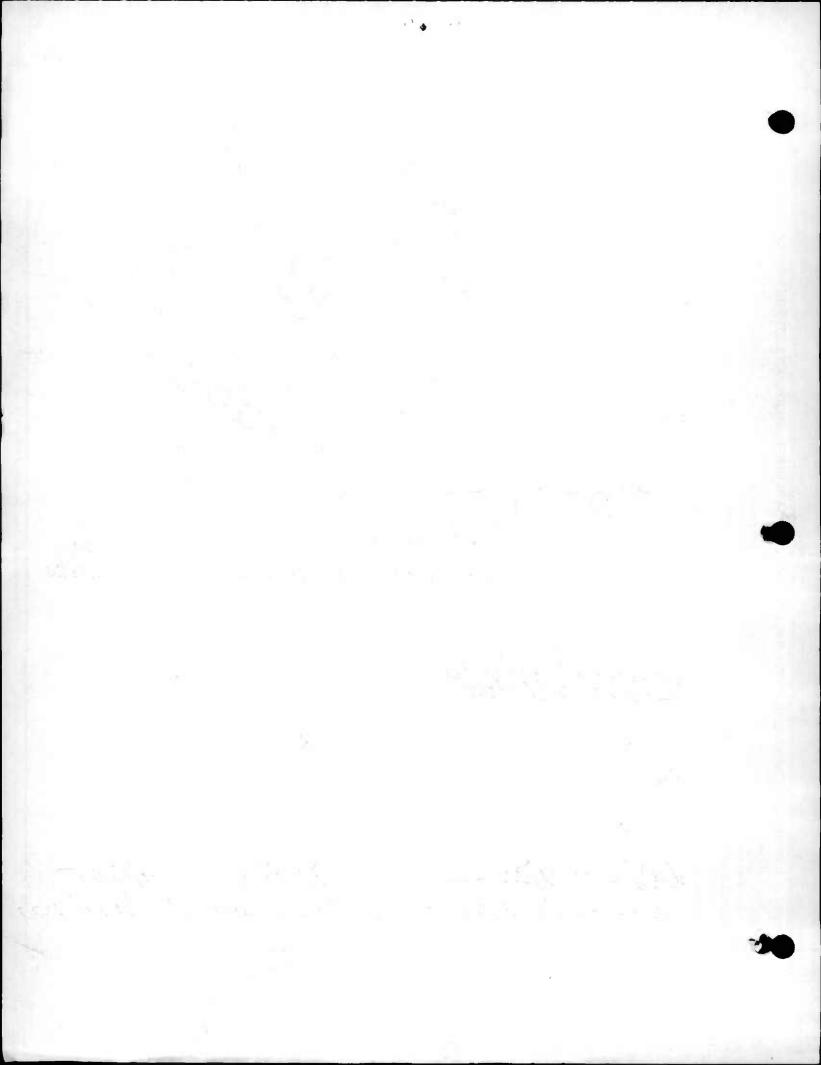
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4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 216-30-4528 61 1 X M 2 | F YRS Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 9233 Grant Avenue Laurel RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10a STATE 10h. COUNTY Maryland Howard Laurel FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 9233 Grant Avenue 20723 use as the burial-transit urs after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 1 Never Married 2 Married B 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) for Elamentary/Secondary (0-12) College (1-4 or 5+) 10 Highway Technician be detached 17. FATHER'S NAME (First, Middle, Last) Ħ Gilbert R. Souder 8 page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 2 Tammy Merson 9 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20s. METHOD OF DISPOSITION METHOD OF DISPOSITION
 Burlal 2 Cremation 3 Removal from State
 Donation 5 Other (Specify) must director, Meadowridge Memorial Park examiner 21. SIGNATURE OF FUNERAL SUID-HAT LICENSEE 22. NAME AND ADDRESS OF FACILITY filled in by the funeral on, or removal. grea the medical cremation, or IMMEDIATE CAUSE (Final disease or condition resulting in death) ysician and completely f prior to burial, crematio event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING been signed by the attending physician it. of Health and Mental Hygiene prior to 2 CAUSE (Disease or injury other **OUE TO (OR AS A CONSEQUENCE OF)** that initiated events resulting in death) LAST 0 in uny PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL that shows any requires PHYSICIAN: certificate has been the State Dept. of 23 25. WAS CASE REFERRED TO MEDICAL Hem FYAMINER? OTHER: 1 YES 20 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Rasidence ATTENDING PHYSICIAN marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? this co INJURY 1 Natural 5 Pending 1 YES 2 NO After t death ВҰ Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) THE HOSPITAL DR ATTENDIN THE FUNERAL DIRECTOR: Af if filed within 72 hours after de 28 is I 3 Suicide ETED e Could not be determined 4 Homicide IMPORTANT: It Item COMPL AND TITLE OF CERTIFIER LICENSE NUMBER BE 223 9 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR Gilbert Gerald Souder April 18, 1995 5:30 a M 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) Jan. 21, 1934 Laurel, Md 9c. COUNTY OF DEATH Howard 10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Ricen, etc.)

1 YES XXVNO Specify: 14. RACE — American Indian, Black, White, etc. Specify: white 16b. KIND OF BUSINESS/INDUSTRY State Highway Administration 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Edna Redmiles 19b. MAILING ADDRESS (Street and Number or Rural Boute Number City or Town, State Zin Code) 408 Maiden Choice Lane Catonsville, Md. 21228 20c. LOCATION — City or Town, State Dorsey, Maryland Donaldson Funeral Home P.A. 313 Talbott Ave. Laurel, Md. 20707 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiretory arrest, abock, or heert failure. List only one cause on agch lina. Approximata Interval Batween Onest and Death orcinava 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MAR ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 | YES 2 | NO 26. PLACE OF DEATH (Check only one) e C Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29d. DATE SIGNED (Month, Day, Year) 8 22. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) Davidson Rondall 1995 2 APR



VEAR

995

9c. COUNTY OF DEATN

Howard

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 YES 2 NO

S. BIRTNPLACE (State or Foreign

Maryland

10g, CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, atc.

White

REG. NO

2. DATE OF DEATN

APRIL

IF UNDER 24 HRS.

7. DATE OF BIRTN (Month, Day, Year 217-48-7247 July 1 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Lorien Nursing Home Columbia 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Howard Ellicott City permit. FUNERAL 101 ZIP CODE page 5 should be detached for use as the burial-transit i 9080-C Town & Country 21043 after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married ΒY 3 🔀 Widowed 4 🗌 Divorced ETED. 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 COMPL Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) John R. notified at Sullens Anna Beck BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Marilyn Blake 4786 Beechwood Road Ellicott City, Maryland 21043 pe 20s. METNOD OF DISPOSITION
1 M Buriel 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, New Cathedral the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc Lowner 4112 Old Columbia Pike Ellicott City 21043 n and completely filled in by the f to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic event, BOX 68760 requires that the death certificate be executed CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING attending physician CAUSE (Disease or injury other the attending phy. DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST injury, or DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY een signed by th of Health and N PERFORMED? shows any 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square certificate has be h the State Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EYAMMED? HOSPITAL 1 YES 2 MO Inpatiant 2 - ER/Outpatiant 3 - DOA 4 Nursing Nome 5 Rasidence 6 Other (Specify) marked, or the 27. MANNES OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED this c 1 Natural 1 YES 2 NO BY After t death Investigation 2 Accident 26s. PLACE OF INJURY — At home, farm, straet, factory, offica building, stc. (Specify) 3 Sulcida THE HOSPITAL OR ATTENDIS THE FUNERAL DIRECTOR: AI filed within 72 hours after de item 28 is COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL IDEA FILED WITHIN 72 H (Check only one) 2 MEDICAL EXAMINER: On the basis of axa desth occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE G-GM 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 12, REGISTRARIS SIGNATURE 31. DATE FILED (Month, Day, Year)

101

6. AGE (In yrs. last birthday)

5 SEX

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

APR 2 71995

Ma

4. SOCIAL SECURITY NUMBER

20c. LOCATION - City or Town, State Apr 28 Baltimore, Maryland intervai Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 26f. LOCATION (Street and Number or Rural Route Number, City or Town. State) 29d. DATE SIGNED (Month, Day, DHMH-16 Rev 1/69

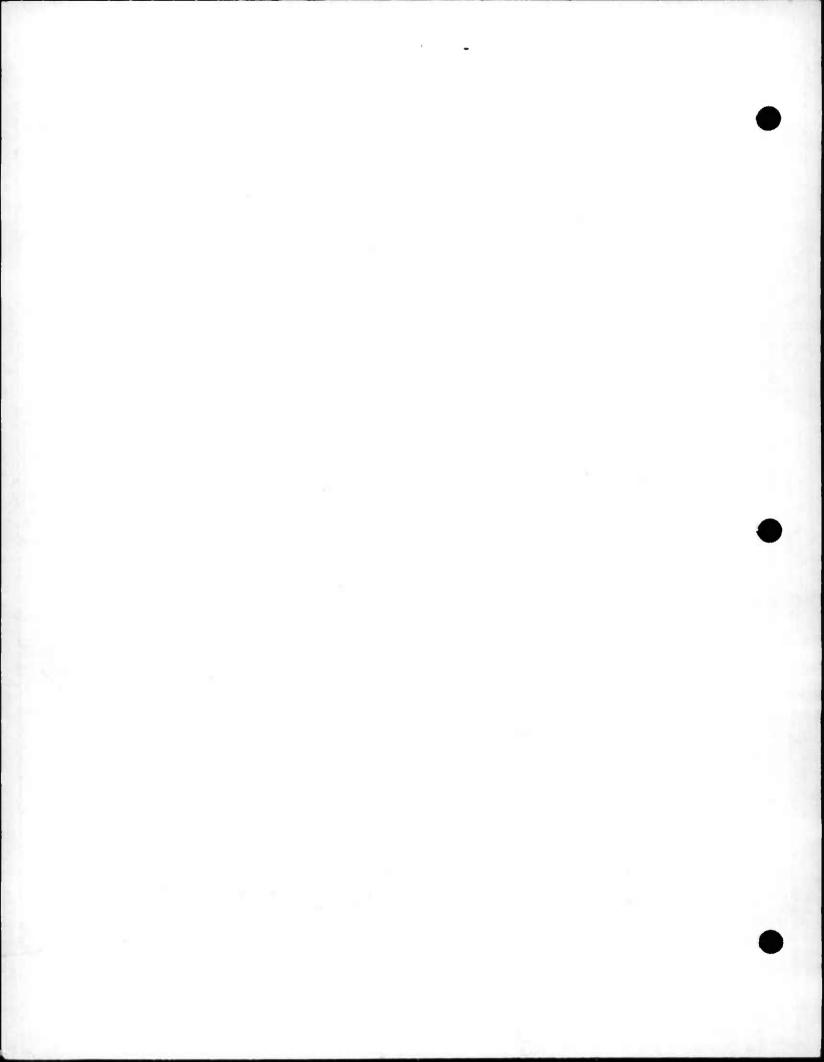
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transf nermit. Pages 1 2 sebraind	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	F. If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTEN	D THE FUNERAL DIRECTOR	e filed within 72 hours after	MPORTANT: If item 28 is marked

STATE OF MARYLAND / DEPARTMENT OF HEALTH /	AND MENTAL HYGIENI
CERTIFICATE OF DEAT	H REG NO

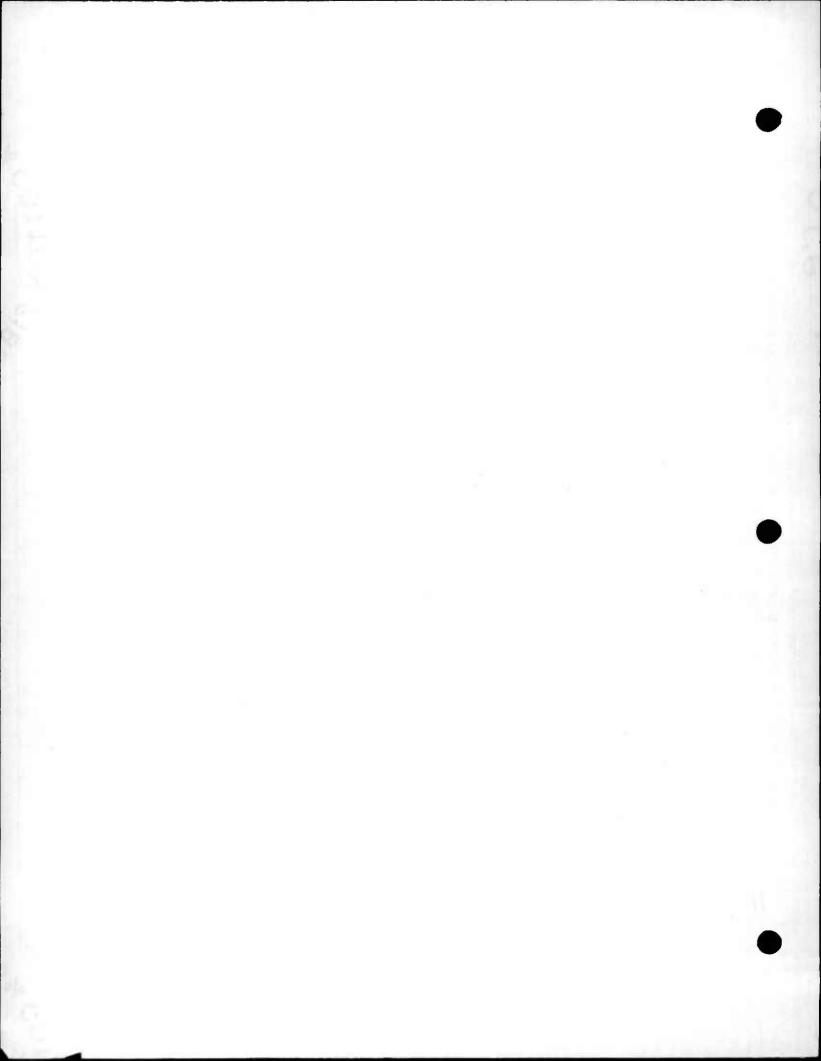
	1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN						
	1. OECEDENT'S NAME (First, Middle, Last)				DEA	2. DATE OF DEATH MONTH	MY YEAR	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER		in yrs. lest birthday)	GER		APRIL 19		5:06 A M				
			in yrs. lest birthdey) 47 YRS,	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign intry)				
	9s. FACILITY NAME (If not institution, give stree		1/	9b. CITY, TOWN	OR LOCATION OF D	Sept. 19,	1946 Ma					
CTOR	SOUTHERN MARYLAND			CLI		ZEAIN		E GEORGES				
DIRECTOR	MARYLAND PRINCE	GEORGES		TY, TOWN OR LOCA ELTENHAN				10d, INSIDE CITY LIMITS? 1 YES 2 NO				
3AL	10e. STREET AND NUMBER			10	f, ZIP CODE	22		WHAT COUNTRY?				
NEF	10316 ANGORA DRIVE				206			USA				
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	If yes, s	CENDENT OF HISPA Hecify Cuben, Mexic 5 2 NO Speci	NIC ORIGIN? (Specify Yean, Puerto Rican, atc.)	Yee or No — 14. RACE — American Indian, Black, White, etc. Specify: White						
COMPLETED	15. OECEDENT'S EDUCAT (Specify only highest grade co	TION ompleted)		USUAL OCCUPATI		16b. KINO OF BU	SINESS/INDUSTRY					
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	or or morning	Dulle	Meil					
MP	12 17. FATHER'S NAME (First, Middle, Last)		Superv	ISOr		Bulk						
	Howard Nicholas Le	dnim				AME (First, Middle, Maiden tte Claire						
BE	19a. INFORMANT'S NAME (Type/Print)	arum	10h MAII IN/	ADDRESS (Small		Route Number, City or Tox						
5	William E. Songer					Cheltenham		23				
	20e. METHOD OF DISPOSITION 1xt Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of campletoy, cramatory of campletoy, cramatory of campletoy, cramatory of campletoy of camplet											
	21. SIGNATURE OF FUHERAL SERVICE LICEN				ND ADORESS OF F							
		ohawn M00		P. 0	Funera Box 15	6. Waldorf	, MD 206	04-0156				
	23. PART I. Enter the diseases, or con ahock, or heert failure. Lis	nplications that caused	the death. Do	not enter the mo	da of dying, su	ch ss cardiac or resp	iratory srrest,	Approximata				
	Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Onset and Death Due to (or as a consequence of):											
_			_	n! Necui		1						
<u> </u>	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):								
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	OUE TO (OR AS A	Hypery	ension								
E	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE O	F):								
CERTIFICATION	d			Alka								
PHYSICIAN: MEDICAL	PART II. Other algorificant conditions of SIP Spiene cto	contributing to death bu	at not resulting	In the underlyIn	g cause given in	Part I. 24a. WAS AN		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
Ö	JIP SPHEME GTO	~~				1 D YES 2	. □ NO	COMPLETION OF CAUSE DF DEATH?				
M				-/				1 YES 2 NO				
AN	DID TOBACCO USE CONTRIE			S MO C	UNCERTAI	N 🗆						
SICI	EXAMINER?	IOSPITAL:		TH (Check only one) OTHER:								
H-XS	27. MANNER OF DEATH	Impatient 2 ☐ ER/Outpu 28e. DATE OF INJURY	28b, TIM			6 Other (Specify)						
9	1 🗷 Netural 5 🗌 Pending	(Month, Day, Year)			RK?	28d. DESCRIBE HOW I	NJURY OCCUREO					
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, ferm,			261. LOCATION (Street a	and Number or Burn	I Bouts Number				
COMPLETED	4 Homicide determined	building, atc. (Speci	fy)			City or Town, State)	and themselves the	Tours Humber,				
7	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	edge, death occum	ed at the time, date	end place, end due	lo the ceuse(e) end mar	nner ee atated.					
Š	one) 2 MEOICAL EXAMINER: (On the basis of examination	and/or investigation	on, in my opinion, d	eath occured at the	time, data and place, an	d due to the cause	(s) and manner es stated.				
H	296. SIGNATURINAND TITLE OF CERTIFIER)ann	M M	0	29c. LICENSE NU	1	29d. DATE SIGNE	(Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO C	1		Print) 17 (O OLI	D LINE C						
	31. DATE FILED (Month, Day, Year)	132. REGISTRAR'S SIGNA	TUBE	W	ALDORF	- and	20	602				



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		1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTA	L HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		YEAR 3	. TIME OF DEATH
		JOHN DA'								2:50 P M	
P		214-05-5035	1 □ N 2 □ F 84	In yrs. lest birthday) YRS.	MONTHS DAYS	HOURS MIN.	NOV	OF BIRTH h, Day, Year)		Country)	ACE (State or Foreign
3 should	<u>۳</u>	98. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH OCHARDED AND AND AND AND AND AND AND AND AND AN									
1, 2,	ECTO	MEMORIAL HOST		100 0171	Y, TOWN OR LOCA	ERLAND			ALL	EGAN	
nit. Pages	E		LLEGANY		CUMBERL				10d. INSIDE CITY LIMITS? tXX YES 2 \(\text{\text{N}} \) NO		
st permit.	ERAL	100. STREET AND NUMBER 1005 HARDING AVE	MILE		10	Of. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
cian. Ftran	FUN	11, MARITAL STATUS	12. WAS DECEDENT EVER IN	III C ADMED	40 1110 05	21502			U.S		
215-0020 attending physician. use as the burial-transit	BY FL	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1XXYES IF YES, GIVE WAR OR DA U.S. NAVY WW]	2 NO	2 NO If was specify Cuban Maxican Puerto Rican etc.) Black, White, etc.						Vhite, etc.
r attending use as the	TED	15. DECEDENT'S EDUC (Specify only highest grade		18e. DECEDENT'S	USUAL OCCUPAT		16b	KIND OF BUS	SINESS/INOU	STRY	
0 -	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	EER FIREN	(A)	OHEEN	OT ITS	D D ET 11	- DV
AND the hospital detached to once.	COMP	17. FATHER'S NAME (First, Middle, Last)		ASSISTAN	I ENGIN			QUEEN		RKEMI	SRY
A SE SE SE SE SE SE SE SE SE SE SE SE SE	C	BRUCE P. STRAW				18. MOTHER'S N.					
E E E T	8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street	and Number or Rural		MONTG		anda)	
- 2 2 0		RONALD J. STRAW				LANE NE (21502
ORE 6 may stor, pa		20aXMETHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Remo 4 Donation 8 Other (Specify)	val from State 20b.	PLACE AND DATE	OF DISPOSITION /A		DAT	F 20c LO	CATION — CI	ly or Town	, State
Page al direc		21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	JECKEDI (22. NAME A	ND ADDRESS OF F	ACILITY			ND ME	IKILAND
BALTIN ter death. Pag the funeral di val.		· Dale L.	Perut		404 DI	TT-ADAMS ECATUR ST	CREET	CUMBE	RLAND	MARY	/LAND
hours after of in by the or removal.		23. PART I. Enter the diseases, or can ahock, or heart fellure. L	omplicetions that caused list only ons ceuse on es	the deeth. Do n	ot enter the m	ode of dying, au	ch ea cerd	diec or reapl	ratory arres	ıt,	Approximate Interval Between
filled I		IMMEDIATE CAUSE (Finel disease or condition									Onset end Death
ted within the completely fille (al. cremation, event, the		resulting in death)	Renal cyst								5 years
Z 5 - 6			Sepsis	CONSEQUENCE OF	·);						1 male
DX 68 be execute cian and co or to buria aumatic	틸	Sequentially list conditions, if any, lesding to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7):						l week
	5	CHOSE (Disease of Hilling)	Pyelonephr								1 week
h certificate anding physical Hygiene pr	CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (OH AS A	CONSEQUENCE OF	·);						
the death y the attend Mental H		PART II Other significant conditions									
Z S A S Z	일	PART II. Other significent conditions	contributing to deeth bu	it not resulting l	n the underlyin	ng cause given in	Part I.	24a. WAS AN. PERFOR	IMED?	AM CC	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
L KECO law requires th as been signed lept. of Health 23 shows an	MEDIC						_ 1				YES 2 NO
	AN	DID TOBACCO USE CONTR					NØ				
IN: The ficate h State State	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 X Inpatient 2 ER/Outpa	8. PLACE OF DEAT	OTHER:						
SICIA certif	PHY	27. MANNER OF DEATH	28e. OATE OF INJURY	28b. TIME		ne 5 🗆 Residence	_	CRIBE HOW IN	WILLIBA OCCIS	DED	
DING PHY After this death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	LINI	URY W	ORK? YES 2 NO		onibe non i	100111 00001	neb	
TTEN TTEN TOR: after		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, ferm, s	treet, fectory, offic	Pry, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)				s Number,	
	12	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowle	death occurre	d at the time, date	end place, end due	to the ceu	se(e) end men	ner ee stated.		
HOSPITAL FUNERAL within 72 I	COMPLETE		: On the beele of examination	Investigation	n, in my opinion, o	death occured at the	time, date	end place, and	d due to the c	ceuse(e) en	d menner ee stated.
TO THE HOSPITAL TO THE FUNERAL DE fied within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CERTIFIER	all 12			29c. LICENSE NU					onth, Day, Year)
* * E 5 3 ₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	סוטכ ע	0		- illoci	1 15/	() ()
11		Dr. Vik Poonai, 9	55 Frederick	Street.		rland, M	D_21	502			
		31. DATE FILED (Month, Day, Year) APR 1 3 1995	32. REGISTRAR'S SIGNA	ardall							
	الــــــــا	CPPI G I DIN	Acces								



Of the wind of the control of the co	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transf nermit. Panes 1 2 sebould) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within T. hours after death. Page 6 may be retained by the hospital or attending physician.	
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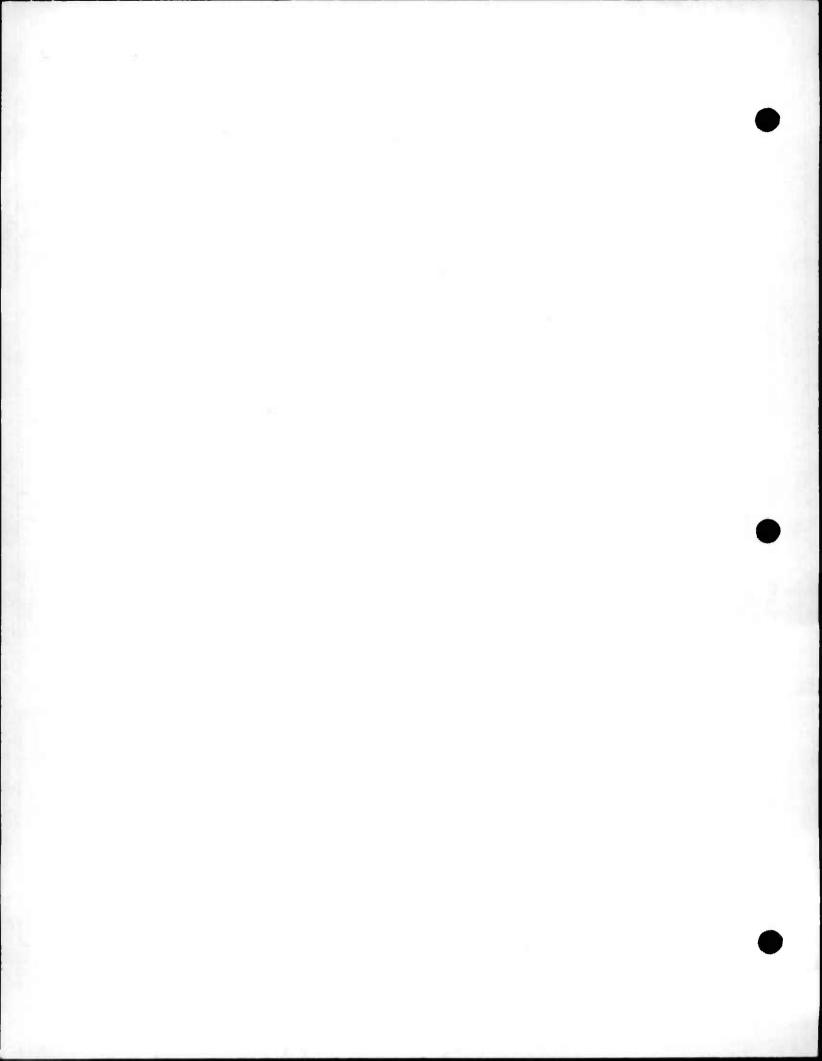
										9	5	13538	
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMEN	T OF H	DEAT	AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH	
	PAUL A.	•	SALKELD						APRIL 4	DAY	1995	12:57P M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las	l birthday)	IF UND	FR 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH & BIRTHRI ACE (State of E				
9	231-18-4535	1 XM 2 - F	71	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	ດວວ	Country	v)	
1	9e. FACILITY NAME (If not institution, give :	street end number)			9b. CIT	Y, TOWN	OR LOCATION	ON OF D	June 20 1		UNTY OF D	na Fulton c	
TOR	Memorial Hosp		Cumberla	and			rlan				llega		
DIRECTOR	10e. STATE 10b. COUNT	edford		10c. CIT		OR LOCA						10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER			1		1 10	ZIP CODE			I		1 TES 2 NO	
FUNERAL	RD 1 Box 54A					100	1553	_		,	usa	HAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOEN FORCES? 1 IF YES, GIVE W		MED 40	13	Il yes, sp	ENDENT Cocify Cuba	n. Maxica	NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.) y:	a or No	Specif	- American Indian, , White, etc. y: White	
0	15. DECEDENT'S EDU	ICATION	16a, DE	CE OENT'S	USUAL (OCCUPATION	ON		16b. KIND OF BU	ISINESS/II		WILLCE	
COMPLETED	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5	+)				sl of workin				truct	ion	
Ž	17. FATHER'S NAME (First, Middle, Last)			reave		101Pii						1011	
BE CC	11oyd E. Salke	eld					18. MOTH	HER'S NA	ME (First, Middle, Melder Bessie				
TO B	190. INFORMANT'S NAME (Type/Print) Mrs. Bonnie Fett	er	198	b. MAILING RD	AODRES	SS (Street a	nd Number	or Rural	Route Number, City or Tow	vn, State, 2	Elip Code)		
206. METHOO OF DISPOSITION 1 Dispurie 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 1 SIGNATURE OF FUNERAL DERIVICE LIDENSEE 206. NETHOO OF DISPOSITION Name of Cemetery, Crematory or other place) 206. PLACE AND DATE OF DISPOSITION Name of Cemetery, Crematory or other place) 206. LOCATION — City or Town, State Breezewood, Pa, 21. SIGNATURE OF FUNERAL DERIVICE LIDENSEE 1 207. LOCATION — City or Town, State 208. LOCATION — C								, Pa, 15533					
	snock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final										Approximata Interval Between Onset and Death 2 months		
CERTIFICATION	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	(OR AS A CONSEC										
EDICAL	PART II. Other significant condition	ns contributing to	death but not n	eaulting	in tha u	ndariyin	3 cause g	iven in	Part I. 24s. WAS AN PERFO	RMEO?	7 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
N. M	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	SX	NO [UNC	ERTAII	N D			1 YES 2 NO	
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSSIE	26. PLAC	E OF DEA									
Š	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE		e 5 □ Re	eldence	6 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	26e. DATE OF (Month, D		26b. TIM		28c. INJ WO	URY AT RK?		28d. DESCRIBE HOW INJURY OCCURED				
TED BY	2 Accident Investigation 3 Suicide 8 Could not ba detarmined								oute Number,				
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI One) 2 MEDICAL EXAMINE								to the cause(e) and me				
8	The state of the s		anwor I	angarit	, as my	-princit, 0	-anii occun	es at the	unie, until enti piaca, er	ra true to	trie Couse(e)	end menner as stated.	
BE	296. SIGNATURE AND TITLE OF CHITISE	Cn	10				29c. LICE	NSE NUN 3497			TE SIGNEO	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS					D4.	フィフィ			121	7 , 1, 1, 7,	

DR. DANIEL LEIBMAN, 31. DATE FILEO (Month, Day, Year) APR 1 2 1995 MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD REGISTRAR'S SIGNATURE

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

21502



1995

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Allegany

3. TIME OF DEATH

W.VA.

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

Specify: WHITE

TX YES 2 NO

Approximata

Interval Betw

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 YES 2 NO

Ogset and Death

7:08PM

8. BIRTNPLACE (State or Foreign

REGISTRAR CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) A MONTH 1 10 DAY Creed George Smith 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. A (Mognin, Pag Your) 1916 1 M 2 | F 78 214-07-6639 funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 96 CITY, TOWN OR LOCATION OF DEATH 331 Dorn Ave. DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION MARYLAND ALLEGANY CUMBERLAND FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 331 DORN 21502 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puarto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 FORCES? 1XXYES 2 NO
IF YES, GIVE WAR OR DATES
WWII US ARMY 1 Never Married 2 Married BY 1 YES 2 NO Specify 3 X Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 OWNER OPERATOR SMITH ZEITH TV INC. TV SALES & SERVICE OUCE. 17. FATHER'S NAME (First, Middle, Leat) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at JOHN HENRY SMITH BE BESSIE ELIZABETH SMITH notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 VICKIE DIAZ 14306 N. BEL AIR <u>DRIVE S.W. CUMBERLAND MARYLAND</u> pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must OATE 1 X Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) SUNSET CEMETERY APRIL 14 1995 CUMBERLAND MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME n by the freenoval. 404 DECATUR STREET CUMBERLAND MARYLAND medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory screat, completely filled in by fal, cremation, or remo shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Finsi the disease or condition Arteriosclerotic heart disease resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF): hysician and com traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate cause. Enter UNDERLYING TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be it THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traun CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO ME UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCURED Natural Accident 5 Pending BY 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Sulcida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only

FOR

MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. April 10 1995 298 GIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER D 09157 Dpty Med Ex Paul Snow, M.D. 124 w3rd st Cumb Md 21502

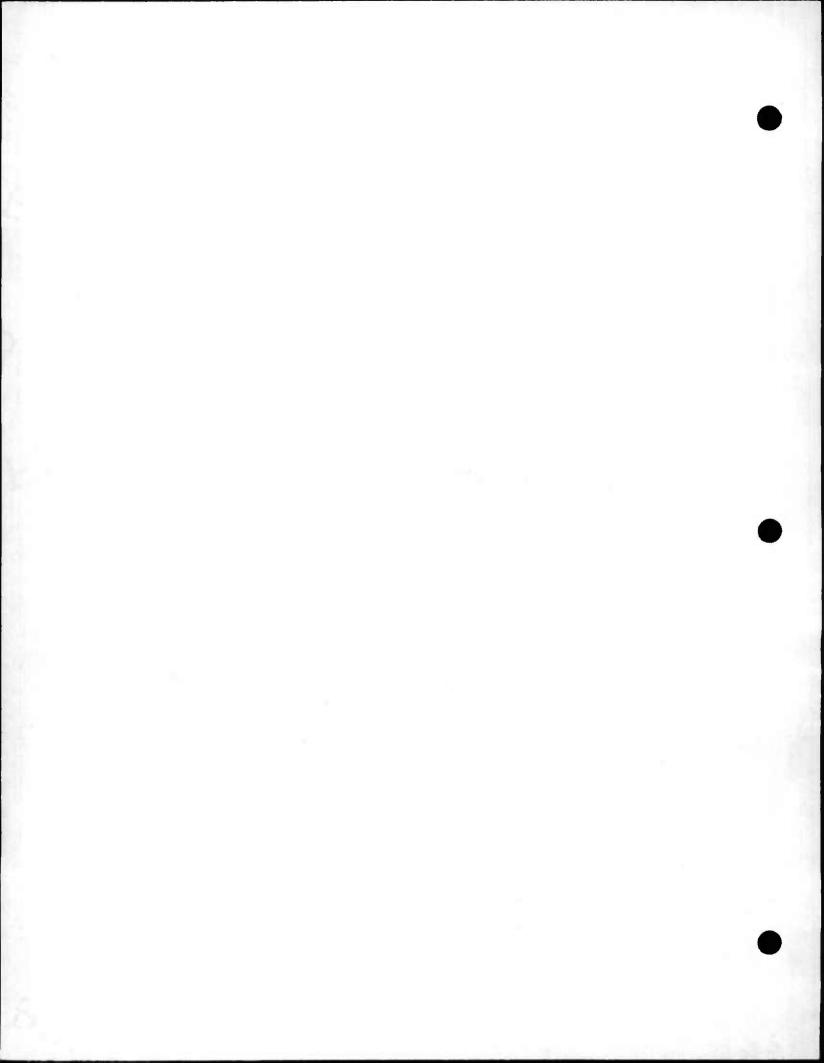
32 REGISTANT'S SIGNATURE NO.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BE

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31. DATE FILEO (MONT)



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F VITAL RECORDS, P.O. BOX 68760	SICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending phys	

		1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MAY YE	3. TIME OF DEATH	
		Richard	Henry	Thor			04 08	199	5 0640 M	
	1			n yrs. last birthday) Q YRS.	MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0	BIRTHPLACE (State or Foreign Country)	
Pino		159-16-6351 9a. FACILITY NAME (If not institution, give stre		80 YRS.	9h CITY TOWN	OR LOCATION OF D	12/17/1914	4 P	ennsylvania	
, 2, 3 should	DIRECTOR	31080 College Backb			A	ess Anne	EATH	- A	nerset	
permit, Pages 1,) H	10a. STATE 10b. COUNTY		10c. CI1	TY, TOWN OR LOCA	TION			10d. INSIDE CITY	
Ę.		Maryland Some	erset	F	rincess A	nne			1 TES 2 NO	
	RAL	100. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN	OF WNAT COUNTRY?	
Jian. -trans	NER	31080 College Back	bone Road 12. WAS DECEDENT EVER IN	III C ADMICO	1 40 1110 054	21853		L US		
215-0020 attending physician. Ise as the burial-transit	BY FUN	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— It yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ★ NO Specify: 1. □ YES 2 ★ NO Specify:					
		15. DECEDENT'S EDUCA	TION	44. DECEDENTIS					Black	
- 5 L	ETED	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give kind of	Work done during moise retired.)	ost of working	16b. KIND OF BU	SINESS/INDUST	RY	
Spital spital hed for	길		College (1-4 or 5+)	retired	-educato	r	Univer	sity/Co	llege	
AND 2 the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		. remiev	-equente		ME (First, Middle, Meiden		nede	
₹ 8 € ₹	BE (Isaac Thomas					Aldridge			
MARYLAND retained by the hospits 5 should be detached notified at once.	70	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number, City or Tow	m, State, Zip Cod	0)	
		Claudia Thomas	Ten		<u>as above</u>					
ALTIMORE, teath. Page 6 may be funeral director, page xaminer must be		1 Burlat 2 Cremation 3 Remov	al from State gem	etery, crematory or p	OF DISPOSITION (Na			CATION City		
ALTIMO death. Page 6 funeral directo		21. SIGNATURE OF FUNERAL SERVICE LICE		ringiiii i	Mausoleur 22. NAME AI		4/14 Heb	ron, Ma	ad - Salisbury	
0 = 0		Patricial	a Jolle	4	Jolley	Memoria	l Chapels -	Maryla	nd, 21801	
S = = 5		23. PART I. Enter the diseases, Dr coi ehock, Dr heert feilure. Lis	mplications that caused at only one cause on ea	the deeth. Do	not anter the mo	oda of dying, suc	ch es cerdiac Dr resp	iratory srrest,	Approximata Interval Between	
File file		IMMEDIATE CAUSE (Final disesse or condition	P.	:+	To The	0			Onset and Death	
ted within completely al, cremat		resulting in death) s.	DUE TO (OR AS A	CONSEQUENCE	ny par	eme	*			
6876 ecuted and composite	z		neuron	ruse in	le 1	barner	ato.		15 yms,	
O. BOX 68' ertificate be executi ng physician and c giene prior to bunia	RTIFICATION	Sequentisity list conditions, if sny, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):					
BO cate b thysicial prior	2	CAUSE (Disesse or Injury								
. 0 =	늗	thet initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
0 = 5 - 6	111	d.								
RD at the by the Wind M	()	PART II. Other eignificant conditione	contributing to deeth be	at not resulting	in the underlyin	g ceuse given in	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
RECO requires the seen signed of Health	MEDI						1 TYES 2	NO NO	OF DEATH?	
C S S S S	2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	F DEATH YI	ES 🗆 NO F	UNCERTAI	\Box		1 YES 2 NO	
TAL I	X	25. WAS CASE REFERRED TO MEDICAL			TN (Check only one)	- OTTOLINA				
VIT MAN: 1 Tifficat Tifficat or ife	PHYSICIAN:	the same of the sa	HOSPITAL:	ntient 3 DOA	OTHER: 4 Nursing Hom	ne 5 Residence	8 Other (Specily)			
1 H SP .	E	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF 28c, INJ	URY AT	28d. DESCRIBE NOW I	NJURY OCCURE	D	
NG PHYS ther this ceath with marked	B	2 Accident Investigation	28e. PLACE OF INJURY			YES 2 NO				
DIVISION DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 8 Could not be 4 Nomicide determined	•	28t. LOCATION (Street of City or Town, State)	and Number or Ru	ural Route Number,				
	P.E.	290. CERTIFIER Check only	AN: To the best of my knowle	edge, death occurr	ed at the time, date	end place, and due	to the cause(s) and mer	nner as stated.		
HOSPITAL FUNERAL within 72	COMPLI	one) 2 MEDICAL EXAMINER:							use(s) end manner es stated.	
B 등 표 표	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	C Ho	ann	_ a	29c. LICENSE NUI	15219	29d. DATE SIG	NED (Month, Day, Year)	
₽ £ £ £	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	(TN (ITEM 27) (Type	, Print)	201101	MT. VERN	4	10-10	
			ANNIE EARRIE			00404	IVII. VEKN	1011/1/	2,050	

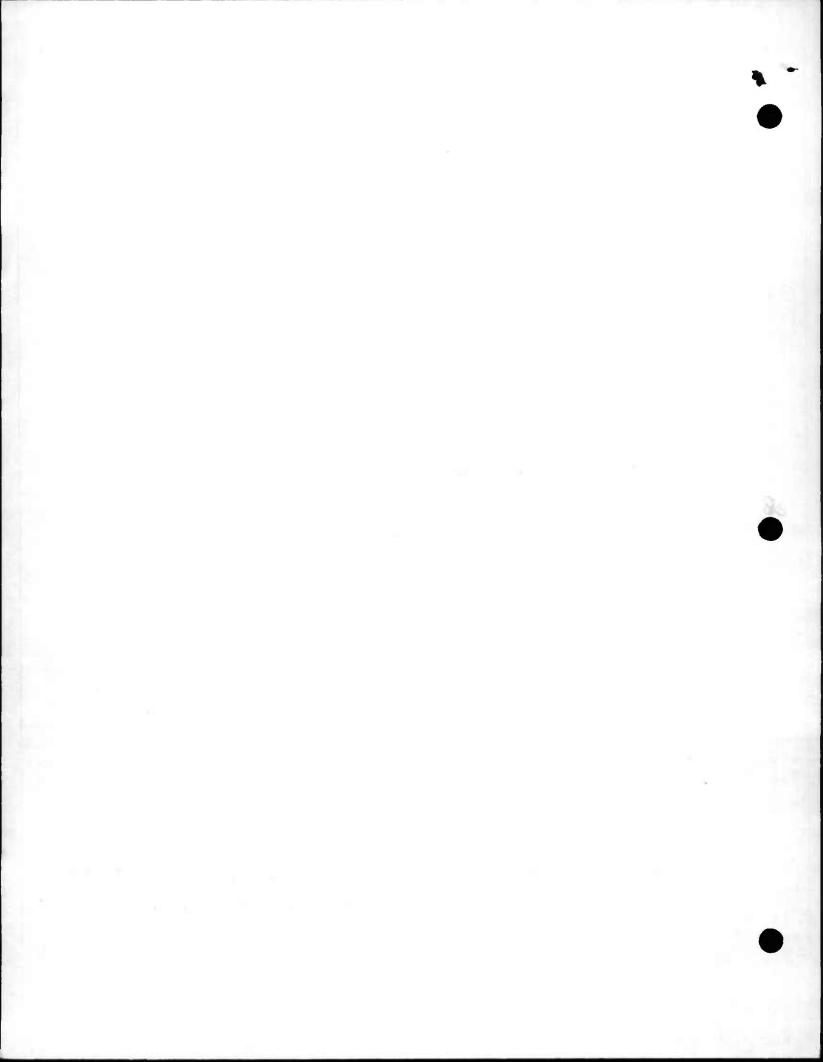
and the second

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	blh _I	TEMS: 2	3 PART I,	27, 28a-f,	PER ME	O FILM G	-723 5	5/19/9	5 t.t	
	1 - FOR STATE REGISTRAR		STATE O	F MARYLAND	DEPART	MENT OF A	DEA	AND N		YGIENE EG. NO.
	1. DECEDENT'S NAME (Firs	t, Middle, Last)							2. DATE OF DI	EATH DAY
	Laura		Nadin	e	Th	omas			April	23
ı	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. I	st birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BI	
	219-20-411	3	1 🗆 M 2 📉	F 66	YRS.	NONTHS DAYS	HOURS	MIN.	Feb. 10	1929

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH										3. TIME OF DEATH			
	Laura					Chomas			Apr	April 23 1995			0254	
	4. SOCIAL SECURITY NUMBER			5. SEX 6. AGE (in yrs. last i		MONTHS DAVI		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Dev. Year)		8. BIRTHPLACE (State or Country)		HPLACE (State or Foreign	
	219-20-4113		1 🗆 M 2 🛴 F	66 YR					Feb.10,		929 Maryland		aryland	
œ	9e. FACILITY NAME (If not institution, give street end number)					9b. CITY, TOWN OR LOCATION OF				EATH 9c. COUNTY OF D			DEATH	
ē	Holy Cross Hospital					Silver Spring Montgomery					omerv			
DIRECTOR	10a. STATE 10b. COUNTY				10c, CIT	10c. CITY, TOWN OR LOCATION				100			10d. INSIDE CITY	
ā	Maryland Montgomery					Silver Spring							LIMITS?	
A	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZEN OF V						
H	10309 Conover Dr.					2090			U.S			U.S.	Α.	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN 1 Never Merried 2 Married FORCES? 1 YES			T EVER IN U.S.AR	13. WAS DECENDENT OF HI 2 NO If yes, specify Cuben, M			ENDENT OF HISPA	ANIC ORIGIN? (Specify Yes or No — 14.				E — American Indian, k, White, etc.	
B	1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR I							2 NO Speci					Specify:	
													Black_	
COMPLETED	(Specify only highest grade completed)			(G	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			ON est of working	16b. KIND OF BUSINESS/INDUSTR			DUSTRY		
7	Elementary/Secondary (0-12) College (1-4 or 5+)			1)	homemaker service				state government			ont		
OM	17. FATHER'S NAME (First, Middle, Lest)				The second secon				IAME (First, Middle, Meiden Surneme)			ient		
EC	Francis Brooks								a Rebecca Willis					
) BE	19a. INFORMANT'S NAME (7)			19	b. MAILING	MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					-			
2	E. Maxine Th	omas									Spring, MD 20902			
	20a METHOD OF DISPOSITIO	ON De la	and the second	20b. PLACE	AND DATE OF DISPOSITION (Name of					DATE 20c. LOCATION — City or Town, State				
	4 Donation 5 Other (Specify)		cemetery, cre	matory or other place) Joy Cemetery				4/2	4/27 Uniontown, MD				
,	21. SIGNATURE OF FUNERAL SERVICE LICENSEE							ND ADDRESS OF FA	ACH ITY					
4	► (athania) (1) Xniller					D.D. Hartzler & Sons Union Bridge, MD					ons			
	23. PART I. Enter the dis	eeses, Dr	complications that	ceused the de	eth. Do n	ot enter	the mo	de of dving, suc	th as card	iec or meni	ratory ar	reet	Approximata	
	anock, or na	art fallure.	List only one cau	ise on each line).	- 111111111				vee bi teapii	atory an	, ,	Interval Between	
	iMMEDIATE CAUSE (Fina disease or condition	1	SMOKE	AND SOOT	INHALA	TION.	THER	RMAL INJUR	TES				Onset and Death	
i	resulting in death)		er-	(OR AS A CONSE					11.0					
z			h										İ	
일	if any, leading to immedi	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disease or injur		c											
#	that initiated events resulting in deeth) LAST	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
照	d													
	PART II. Other significen	t condition	e contributing to	deeth but not r	esulting is	n the un	derlying	cause given in	Part i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS	
<u> </u>											PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL									_	1 X YES 2 □ NO			OF DEATH?	
	DID TOBACCO US	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										TON TES 2 NO		
Š	25. WAS CASE REFERRED TO	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
PHYSICIAN	EXAMINER?		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Residence	6 Other	(Specify)				
Ìξ	27. MANNER OF DEATH	27. MANNER OF DEATH 28e. DATE OF INJURY			Y 28b. TIME OF					28d. DESCRIBE HOW INJURY OCCURED				
BY	1 Netural 5 Pending (Month, Day, Year) 2(TX) Accident Investigation 4/23/95				2:00 A				SUBJECT IN HOUSE FIRE					
	3 Suicide 6 Could not be					ime, farm, atreet, lectory, office			28f. LOCATION (Street and Number or Rural Route Number,					
	4 Homicide determined HOME								City or Town, State) 10309 CONOVER DR., SILVER SPRING, MD.					
ון ב	290. CERTIFIER													
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated.													
	20h SICNATURE AND TITLE OF CERTIFIER													
BE	Donald & Wright MD								, , , , , , , , , , , , , , , , , , ,					
요	30. NAME AND ADDRESS OF	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									23 1995			
	DONALD G.	DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201												
	31. DATE FILED (Month, Day)	TIT FORM SCIENCE DOTLINOTE, MOLVIGIO XIXVI I												
1	TOPE C Z HOD	3 18W	of the market.	Turbally.										

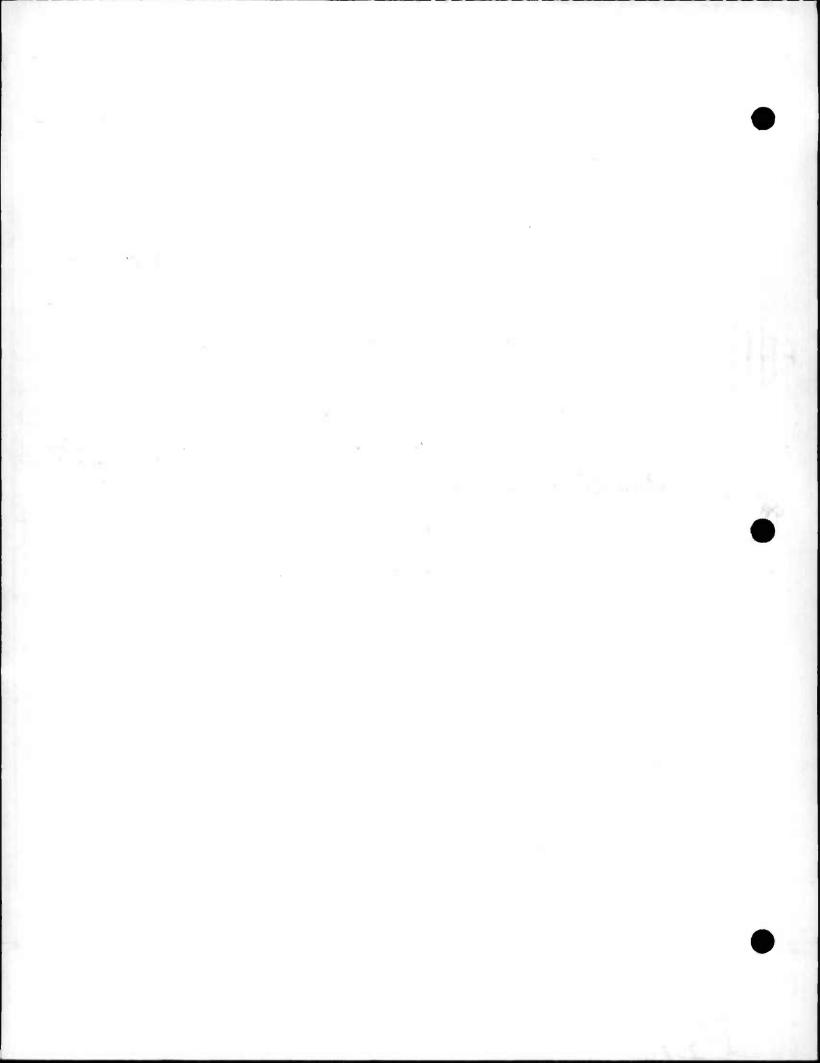


April 23, 1995 1AM CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Mark Scott Teter 2. DATE OF OEATH 3. TIME OF OEATH nart eter month B 2 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Feb 3 1955 DAYS HOURS 1 XM 2 - F 444-54-0073 40 YRS. Oklahoma Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? retained by the hospital or attending physician. 5 should be detached for use as the burial-transit 431 State Street United States 21403 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNX IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 No. Specify: BY 3 Widowed 4 Divorced Specify: White 0 16a. DECEDENT'S USUAL DCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only h Ē (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) Medical Doctor funeral director, page 5 should be detached COMPI Rheumatologist 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ĕ Floyd A. Teter Billie Scott notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Floyd & Billie Teter 3012 East 93rd Ct. Tulsa, Oklahoma 74137 nours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION
1 Burial 2 Tremation 3 Ramo 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE FX. Lincoin Crematory 4/25/95 Brentwood, Maryland 4 Donation 5 Other (Specify). 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home examiner SIGNATURE OF FUNERAL SERVICE LICENSEE 147 Duke of Gloucester St. Annapolis, MD completely filled in by the rial, cremation, or removal. the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete shock, or heart fellure. List only one ceuse on each line. Interval Between attending physician and completely filled in mal Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Finsi Onset end Death disesse or condition Dreumania Zdays resulting in death) traumatic event, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760. DUE TO (OR AS A CONSEQUENCE OF): Tunun defectioncy virus infection CERTIFICATION Sequentisity list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disesse or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 6 Injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by the COMPLETION OF CAUSE 1 TYES 2 THE 23 shows 1 YES 2 NO has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) this certificate h OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) the 0 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO After ti BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 🗌 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 DIRECTOR: / COMPLETED 8 Could not be 28 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29a, CERTIFIER TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE Barves MD eved C April 23, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Printy)

POSUID (RARNES 900 Bestgate Road, Sufe 300 Annaudis and

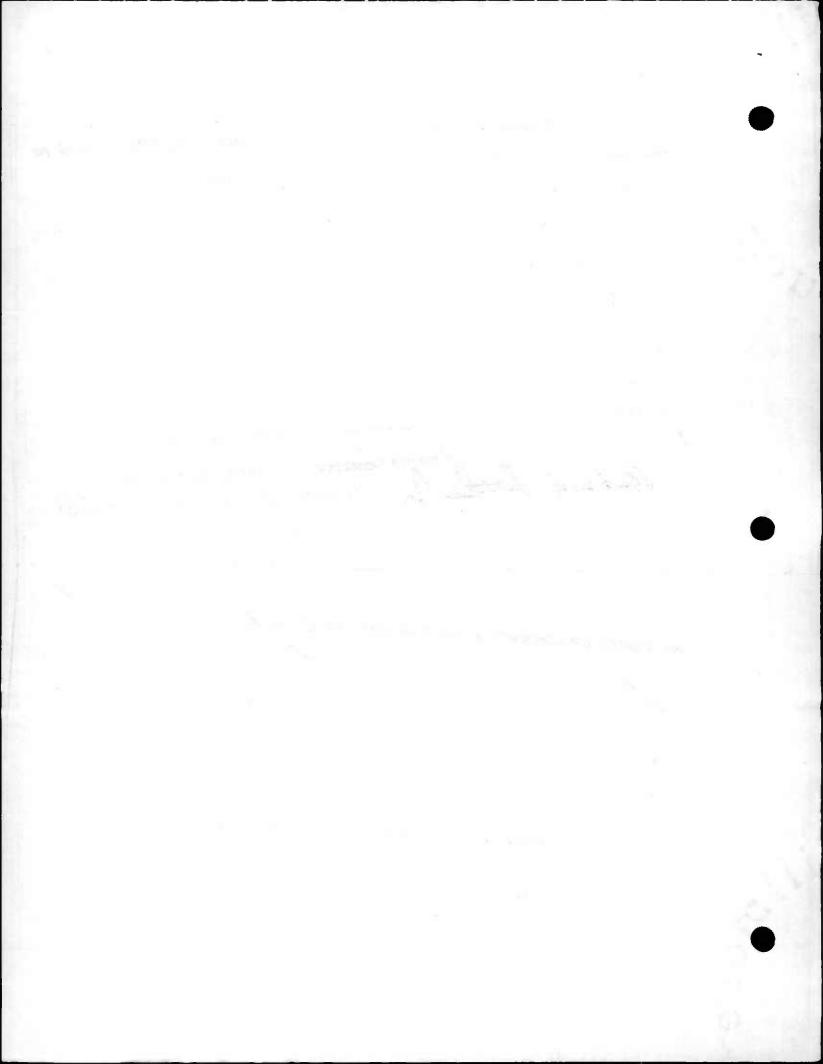
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APR 25 1995 Whi Davideor Rarbell



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a single of the confliction in the conflictio

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN	3. TIME OF DEATN					
	Charl	Cotte M. Troy	ner		April 20.	1995	3:20 pm M				
	4. SOCIAL SECURITY NUMBER		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yeer)	8. BIRTNPI	LACE (State or Foreign					
	1 190-3/-4//9	1 □ M 2 💢 F 52	YRS.	ONTHE DAYS HOURS MIN.	_	Country)	DΛ				
	9e. FACILITY NAME (If not institution, give street		96. CITY, TOWN OR LOCATION OF	January 7	9c. COUNTY OF DEATH						
l e	2606 Myrtle Ave.			Baltimore		Baltimore Co.					
[RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		100 CITY	TOWN OR LOCATION							
DIRECTOR	MD Carro	88	100. 011,	Westminster		10d. INSIDE CITY LIMITS?					
	10e. STREET AND NUMBER			101, ZIP CODE		1 ☐ YES 2 🖄 NO					
R.	647 Cherrytown Rd	1.		21158		USA	AT COUNTRY?				
BY FUNERAL		.S. ARMED	13. WAS DECENDENT OF NISP	ANIC ORIGIN? (Specify Yes		- American Indian,					
	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	It yee, specify Cuben, Mexic 1 TES 2 NO Spec	cen, Puerto Ricen, etc.)	Puerto Ricen, etc.) Black, White, etc. Specify:					
	3 Widowed 4 Divorced	C			,	White					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	FION 16 mpleted)	(Give kind of wo	SUAL OCCUPATION rk done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY					
Ë	Elementary/Secondery (0-12)	life. Do NOT use	retired.)								
g B	12 17. FATHER'S NAME (First, Middle, Last)	Housew			Housewife						
	Elmer Walters				IAME (First, Middle, Maiden	,					
BE	19a. INFORMANT'S NAME (Type/Print)		Total Control		leve Burton						
TO BI	Michael Troyner			DDRESS (Street end Number or Rura							
	200. METHOD OF DISPOSITION			Arbory Way La							
	1 Buriel 2 Cremetion 3 Remove		ry, cremetory or oth			CATION — City or Town					
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISE A ST	.Mary's	Come tory	4/24 Si	lver Run,	₩				
	· 011	1.41	()	Littles'F.H.	2/ M1- A	* * * * * * *	17340				
	23. PART I. Enter the diseases, or con	ance	· h.				stown, PA				
CERTIFICATION	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
							1				
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDIN ANILABLE PRIOR TO										
ĕ					1 🗆 YES 2		OF DEATH?				
ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO										
A											
SC	EXAMINER?	HOSPITAL:		28. PLACE OF DEATH (Check only one) OTHER:							
ΪŽ	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TIME	OF 28c, INJURY AT	8 U Other (Specify) 28d. DESCRIBE NOW II	NILIBA OCCUBED					
	1 Natural 5 Pending	(Month, Day, Year)	INJU		Zou. Degombe Now in	NJONT OCCORED					
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY —	At home, ferm, str		281, LOCATION (Street a	and Number or Bural Boi	ite Number				
	4 Nomicide determined	building, etc. (Specify)			City or Town, State)						
COMPLETE	29e. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee atated.										
N N	(Check only Check only (Check only Check only (Check only Check only (Check only Check only (Check only C										
	2004 SHOMATMER AND SITE OF CONCRETE AND										
	29c. LICENSE NUMBER 29d. DATE SIGNED (Month flow, Your)										
	ON NAME AND ADDRESS OF PERSON WHO COMPLETED PAUSE OF DEATH (ITEM 27) (Type, Print)										
1 1	Franks Grunhing / 6264 N. Hader of later/										
	APR 2 1995 Julia divelor hardal										
	MFK 1333 Java	100001									



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Davidson Rose

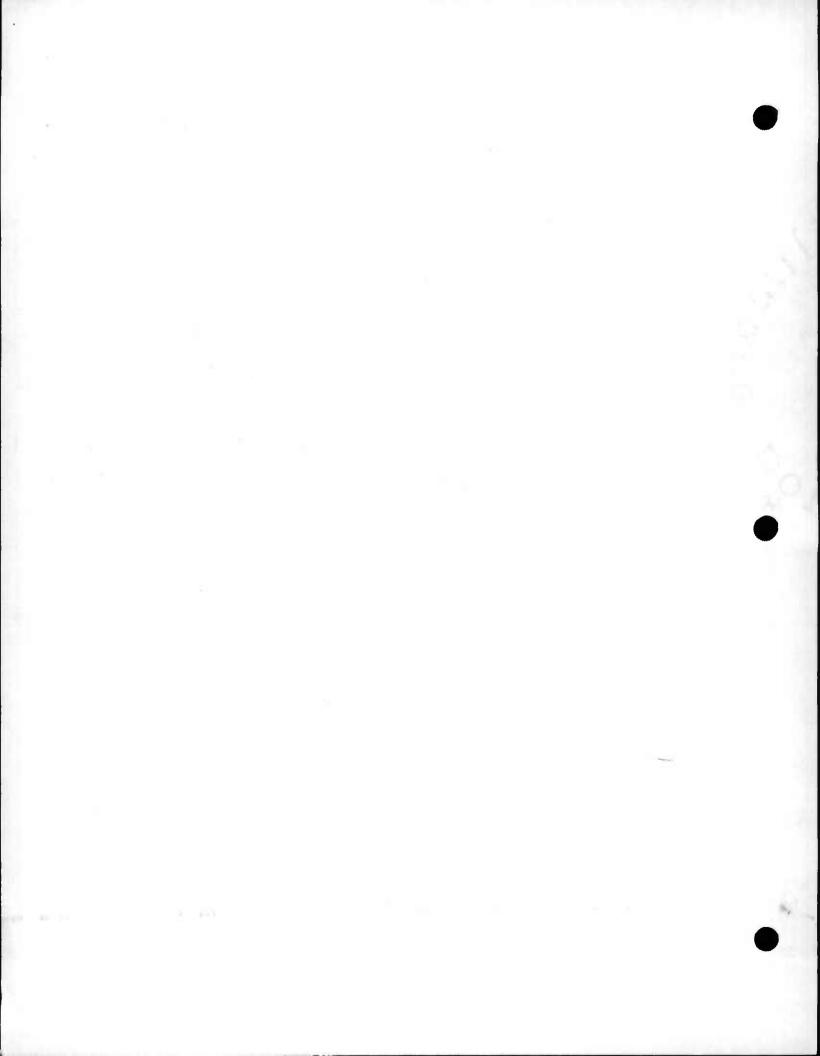
31. DATE FILED (Month, Day, Year)

11

BOX 68760 DIVISION OF VITAL RECORDS, P.O.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR April 7, Earline TAYLOR 1995 9:24 P. 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 091-34-6472 1 M 2 TIF DAYS HOURS MIN. Aug. 02, 1943 Gambrills, MD. permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Lanham, MD. P.G. County Doctors Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. P.G. Seabrook, MD. 1 LYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 20706 use as the burial-transit U. S. A. 5415 97th Avenue retained by the hospital or attending physician. 5 should be detached for use as the burial-tran 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Maintenance Domestic 11th once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)
Doris Smith Charles D. Johnson funeral director, page 5 should be BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Doris Johnson 97th Ave., Seabrook, MD. 20706 hours after death. Page 6 may be pe 20s. METHOD OF DISPOSITION
11 Burlel 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Harmony Memorial Park 4/14/95 Landover, MD. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4804 Ga. Ave., NW James E. Vann F.H. WAshington, D.C. 20011 n by the fremoval. 23. PAIT I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart feilure. List only one cause on each line. in by interval Between 6 filled **IMMEDIATE CAUSE (Fine) Onset and Death** cremation. event, the disease or condition_ and completely for burtal, cremation HEROIN OVERDOSE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events attending resulting in death) LAST signed by the a Health and Men PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO DR ATTENDING PHYSICIAN: The law requires that shows any COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 TES 2 NO t. of has be Dept. (DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: 1 TYES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, 2 Accident 5 Pending UNKNOWN^M 1 YES 2 KNO 4-6-95 BY UNKNOWN After 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .00 6 (Could not be COMPLETED DIRECTOR: / 4 Homicide 28 HOME SAME AS #10 TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If Item 29 29a. CERTIFIER
(Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of exer ninstion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CE 29c. LICENSE NUMBER 29d. DATE SIGNED (Mogth, Day, Year) D15558 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3308 PERRY ST, MT. RAINIER, MD



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PH

After

BE

2

295. SIGNATURE AND TITLE OF CERTIFIER

DR. W. GUY FISCUS

31. DATE FILED (Month

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ALCOHOLOGICA SIGNATURO

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95 13645 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH THEODORE THOERIG APRIL 13, 1995 0157AM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH
(Month, Day, Year)
July 5,1913 8. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOURS 214-07-3576 1 💢 M 2 🗌 F 81 MARYLAND 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR MEMORIAL HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY MT. SAVAGE 1 TYES 2 NO 10a. STREET AND NUMBER FUNERAL 10t, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? BRUCE HOUSE FARM 21545 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If was, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 N YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married It yes, specify Cuban, Maxican, Puarto Ri
1 YES 2 X NO Specify: Specify: BY 3 Widowed 4 Divorced WHITE W.W.II COMPLETED 15. DECEDENT'S EDUCATION (Specity only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY DEPARTMENT OF NATURAL Elamentary/Secondary (0-12) College (1-4 or 5+) AW ENFORCEMENT OFFICER-8 RESOURCES 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) at WILLIAM FRANKLIN THOERIG HARRIETT ANN JENKINS BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9 PHYLLIS THOERIG P.O.BOX 532 - MT. SAVAGE, MD 21545 þ METHOD OF DISPOSITION 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 X Burial 2 Cremation 3 Removal from State MSVC-ROCKY Donation 5 Other (Specify) GAP 4/17/95 FLINTSTONE, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, 202 GREENE ST., CUMBERLAND, MD 21502 medical 23. PART I. Enter the cheases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Onsat and Death IMMEDIATE CAUSE (Final the disease or condition ovanc reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avants resulting in death) LAST Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO апу COMPLETION OF CAUSE DF DEATH? 1 TES 1 Shows 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check onl) Item EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpati DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked. Natural 1 YES 2 NO В Investigation 2 Accident DIRECTOR: Aft hours after dea item 28 is n 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Treen State) ETED 8 Could not be 4 Homicide datarmined 29a. CERTIFIER COMPL LERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If i (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

MEMORIAL HOSPITAL MEDICAL BLDG., 500 MEMORIAL AVE.,

CUMBERLAND,

21502

29d: QATE SIGNED (Month, Day

SOUTH STORY

N

1 - STATE REGISTRAR

The state of Maryland / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

		REGISTRAN		CE	HILL	ICATE	DE DEATH	REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last) WILLIAM DALE THO	MPSON					2. DATE OF DEATH ON APRIL 14	AY 1995				
		4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last	hiethelms	IF UNDER 1 YE	AR IF UNDER 24 HRS.	T DATE OF DIRECT	La ale	7:00 A M			
		235-20-2190	1 [X M 2] F	6.9	YRS.	MONTHS DA		Sept.8,1	Cour	THPLACE (State or Foreign ntry)			
Þ				09	THS.			Sept.8,1		7			
should	 	9a. FACILITY NAME (If not institution, give str	,			100	WN OR LOCATION OF D	9c. COUNTY OF	OEATH				
2, 3	CTOR	SACRED HEART HOS	SPITAL			CUMB	ERLAND		ALLEGAN	NY.			
ες. 	[គួ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			40 - 017	Y, TOWN OR LO				T			
Pages	DIREC	2330300	1					10d. INSIDE CITY LIMITS?					
permit.			ieral		K.	idgel							
bed	FUNERAL	10e. STREET AND NUMBER					10f. ZIP CODE						
020 physician. burial-transit	9	Route 1, Box 48					26753		U.S.	Α.			
215-UU2U attending physician se as the burial-trai	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT, EVE FORCES? 1 X Y	ER IN U.S. ARI	MED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14. RA	CE — American Indian, ick, White, atc.			
5-0020 Inding physic Is the burial	BY	0 C 1984 - 4 0 C m	#FYES, GIVE WAR OR DATES 3 □ Widowed 4 □ Divorced W. W. II & Korea 1 □ YES 2 □ NO							office			
as th										White			
	田田	15. DECEDENT'S EDUC (Specify only highest grade of	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT seelingd.)										
tal or for u	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)			Verent I		D D 0					
the hospital detached fo	₹			2	tore	ekeep	er	P.P.G	•				
the hos detach	COMPL	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Malden					
HYL,	ш	Samuel thompson					Rose	McMillen					
retained 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (Str	eet and Number or Rural	Route Number, City or Tow	n, State, Zip Code)				
	F	Kay M. Thompson		l R	oute	e 1. 1	Box 482 -	-Ridgeley	WV :	26753			
nay be		20a. METHOD OF DISPOSITION	T	20b. PLACEA	ND DATE C	OF DISPOSITION			CATION — City or				
must		1 🕅 Buriel 2 🗆 Cremation 3 🗆 Remo 4 🗆 Donation 5 🗆 Other (Specify)		Cemetery, cren	natory or ot	ther plece)	ial Park	4/17/95 0	umbanl	and MD			
Page 6 may be all director, page		21. SIGNATURE OF FUNERAL SERVICE LICE	F AND ADDRESS OF FA	ADDRESS OF FACILITY									
		mlk , la	7	,	Geoi	rge-Upchurch Funeral Home,P.A. Greene St.,Cumberland,MD 21502							
BAL ter death the funer wal.		GIBNAY YI.		202	202 Greene St., Cumberland, MD 21502								
24 hours after of filled in by the ion, or removal.	- 1	23. PART I. Enter the diseases, or of shock, or heart fellure. L	ist only one cause of	used the dea	nth. Do n	ot enter the	e mode of dying, such as cardisc or respiratory arrest, Approximate Interval Batwee						
E S S S	- 1	IMMEDIATE CAUSE (Finel)	/ /		Onest and Desti							
a e a		disease or condition resulting in death)	Kern	10Ato	en								
vith crent		in coatily	DUE TO OR	AS A CONSEO	UENCE OF	ARK				Phila			
executed with and complete o burial, crem	2		Arus	0 1	Phon	um m	tra			124/10			
evecute and control to buria	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEO	UENCE OF	7:		11		0 11163			
ta picia pe	8	cause. Enter UNDERLYING	Ends	tree	M	m Hm	Saker (unden	m a	12.05			
ther by	Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR A	AS A DONSEO	UENCE OF):	ag print	y nghoi	140	Dyks			
Hydin P	臣	resulting in death) LAST		0		6		/					
the death the attend the attend Mental injury, o	2												
= 0 = 1	A	PART II. Other eignificent conditions	contributing to deat	th but not re	euiting I	n the under	ying ceuse given in	Part I. 24e. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
signed by Health and Was any	EDICAL							1 _ YES 2		COMPLETION OF CAUSE OF DEATH?			
									_	1 YES 2 NO			
The law require has been ate Dept, of Perm 23 sho	2 3	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEAT	H YE	S 🗆 NO	TH UNCERTAIL	v 🗆 l					
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check only							
N: The ficate h State I	S	EXAMINER?	HOSPUML:	Outpatient 3		OTHER:	Home 5 Beeldenee	a [] Otto (Occupant)					
PHYSICIAN: The this certificate to with the State Invited, or Item	PHY	27. MANNER OF DEATH	28a. DATE OF INJU		28b. TIME		Home 5 Residence	28d. OESCRIBE HOW II	N HIDY OCCUPED				
를 를 를 돌		1 A Natural 5 Pending	(Month, Day, Ye	ar)	INJ	URY	WORK? YES 2 NO		icom cocones				
a state	À	2 Accident Investigation 3 Suicide & Could get be	28s. PLACE OF INJ	URY — At hon	ne form e			201 LOCATION (C)		0			
TTEND TTOR: / after d		4 Homicide 8 Could not be	building, atc. (Specify)	100, 1atrii, a	diese, factory,	orrica	28f. LOCATION (Street a City or Town, State)	ind Number or Hural	Houte Number,			
		A. 05000050											
AL DR	COMPLETE	29a. CERTIFIER (Check only one)											
NER/ hin 7	6	2 MEDICAL EXAMINER	: On the basis of sxamin	ation and/or in	rveatigation	n, in my opinio	n, death occured at the	time, data and place, an	d dus to the cause	(s) and menner as stated.			
E HO B With	П	296, SIGNATURE AND TITLE OF SENTIFIES					29c. LICENSE NUI	ABER .	29d. DATE SIGNE	D (Month, Day, Year)			
TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 PAR IMPORTANT; IF IN	∞ ▮	2411	3 ABrel	000			DI	218/	▶ APRIL	411			
FFA	2	30. NAME AND ADDRESS OF PERSON WHO	CONFLETED CAUSE OF	DEATH (ITEM	27) (Type.	Print)	1/20	101	W KIL	17/5			
8		GARY WAGONER, M					CIMPENT ASS.	\m\ a==					
0		31. DATE FILEO (Month, Day, Year)	32. REGISTRANS	GRATURE A	UL OIL	KUAD	CUMBEKLANI	, MD. 215	02				
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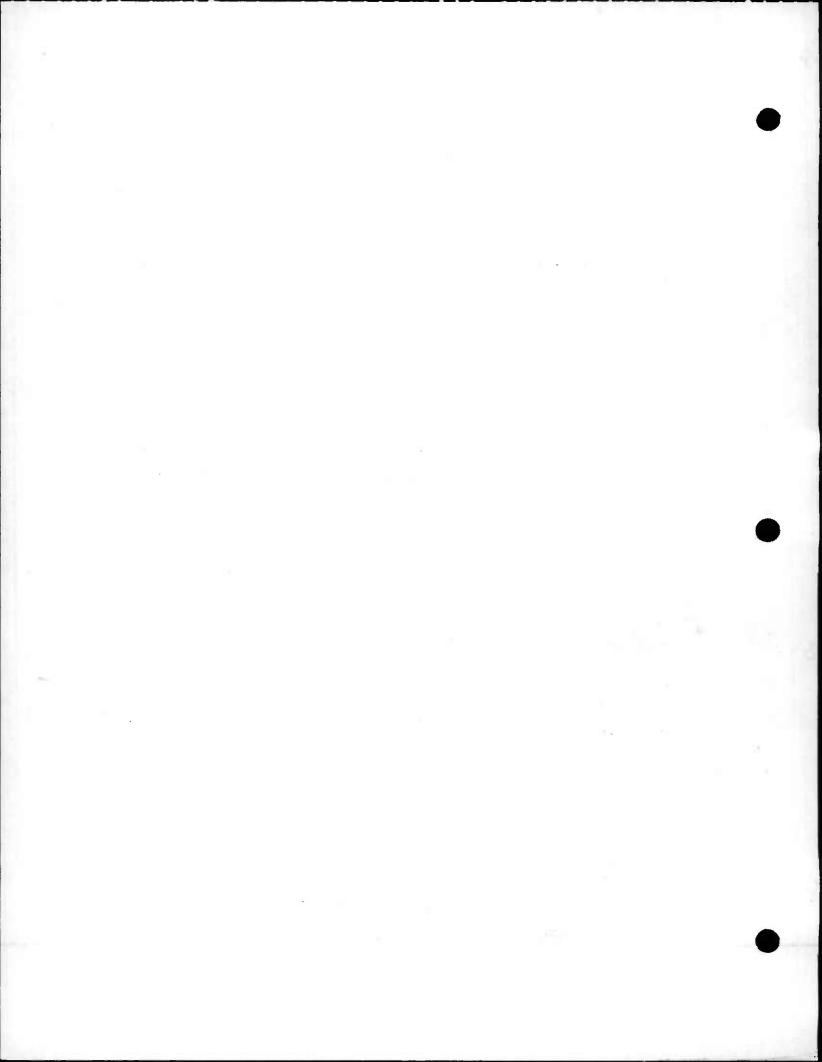
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN
		Mary Al:	ice THOM	1PSON		April :	23, 199	5 6:50 A. M
			140	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8,	BIRTNPLACE (State or Foreign Country)
			7 YRS.			Dec. 18,		Maryland
œ	9a. FACILITY NAME (If not institution, give stre	,	9		OR LOCATION OF D	EATN	9c. COUNTY	• • • • • • • • • • • • • • • • • • • •
Ō.	Citizens Nursing	Home		Frede	rick		Fr	ederick
BY FUNERAL DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCA	ION			10d. INSIDE CITY
ā	Maryland Fre	derick	U	nion B	ridge			1 YES 2 NO
IAL	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZE	OF WHAT COUNTRY?
ZER	9001 Dolly Hyde Ro	oad			21791		U.	S.A.
J.	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Y	ea or No — 14	. RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES TE	1 TYES	2 XNO Specif	у:		Specify: White
	15. DECEDENT'S EDUCA		18a. DECEDENT'S US	UAL OCCUPATION	DN .	16h KIND OF B	USINESS/INDUS	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	(Give kind of worn life. Do NOT use n	k done during mo etired.)	st of working	IOU. KIND OF B	03111233/111003	
릴	12	ounder (1-4 of 5 +)	Homemak	er		Home	9	
ő	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maide	n Surname)	
BE (Charles E. M	URPHY			Mam:	ie E.	WARFIE	LD
5	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To		
-	Mr. Richard C. Tho	ompson, Jr.	9001 D	olly H	rde Road	, Union Br	idge, l	MD 21791
	20s. METHOD OF DISPOSITION 1.A. Burlal 2 Cremetion 3 Remov	ral from State com	PLACE AND DATE OF I	nlacal			OCATION - City	
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Mc	unt Olive	t Cemet	ery, Api	r.125,1995	Freder	ick, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	MSEE O			D ADDRESS OF FA	ord P.a. F	unora1	Home
	Man A	Ruby	MC0703	106 E	ast Churc	ch St., Fr	ederic	k, MD 21701
	23. PART I. Enter the diseases, Dr co shock, Dr heart fallure. Li	mplications that caused	the death. Do not	enter the mo	de of dying, suc	h ea cardlec or res	piratory erreat	
	IMMEDIATE CAUSE (Final	/)	ecii ilile.					interval Between Onset and Death
	diseese or condition resulting in death)	Pulun	runca					1 w/c
		DUE TO (OR AS A	CONSEQUENCE OF):	1	_ ^			
8	Sequentially list conditions,	Alzho	imers	1311	2011			Syrs
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS A	CONSEQUENCE OF):					'
윤	CAUSE (Disease Dr Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
F	resulting in death) LAST		,					
	DADE II. Only and a Mary Ave. May							
CAL	PART II. Other significant conditions	contributing to death b	ut not reaulting in t	the underlyin	cause given in	Part I. 24a. WAS A	N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC			···-			1 YES	2 NO	COMPLETION OF CAUSE OF DEATN?
Σ								1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRI				UNCERTAIL	N 🔲 📗		
S		HOSPITAL:		THER:				
448	1 YES 2 NO	1 Inpatient 2 ER/Outp 28a. DATE OF INJURY	atlent 3 DOA 4			6 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	INJUR	Y WO	RK?	28d. DESCRIBE NOW	INJURY OCCUR	ED
B	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	- At home, farm, atre			281. LOCATION (Street	and Mumber or	Pumi Dauta Mumbar
8	4 Nomicide S Could not be	building, atc. (Spec	elfy)	.,,		City or Town, State	9)	nure: noute number,
	29e. CERTIFIER	ANI, To the best of a						
COMPLETE		AN: To the best of my know						ause(s) and manner as stated.
- 11	296. SIGNATURE AND TITLE OF CERTIFIER							
BE	William Carliner	,			29c. LICENSE NUI	WBER	29d. DATE SI	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) /Rose De	int)	113.10	1 1	17 7/	- 1/9/
	Dr. Gene F. Ashe,				Moodal	ore MD 2	1700	
	31. DATE FILED (Month, Day, Year)	20 05010751516 01011	amaza m	ie Noat	, WOOUSE	OLO, MD Z	1/90	
	APR 2 4 1995	Jalia d'aux	Gor Rarbett					1

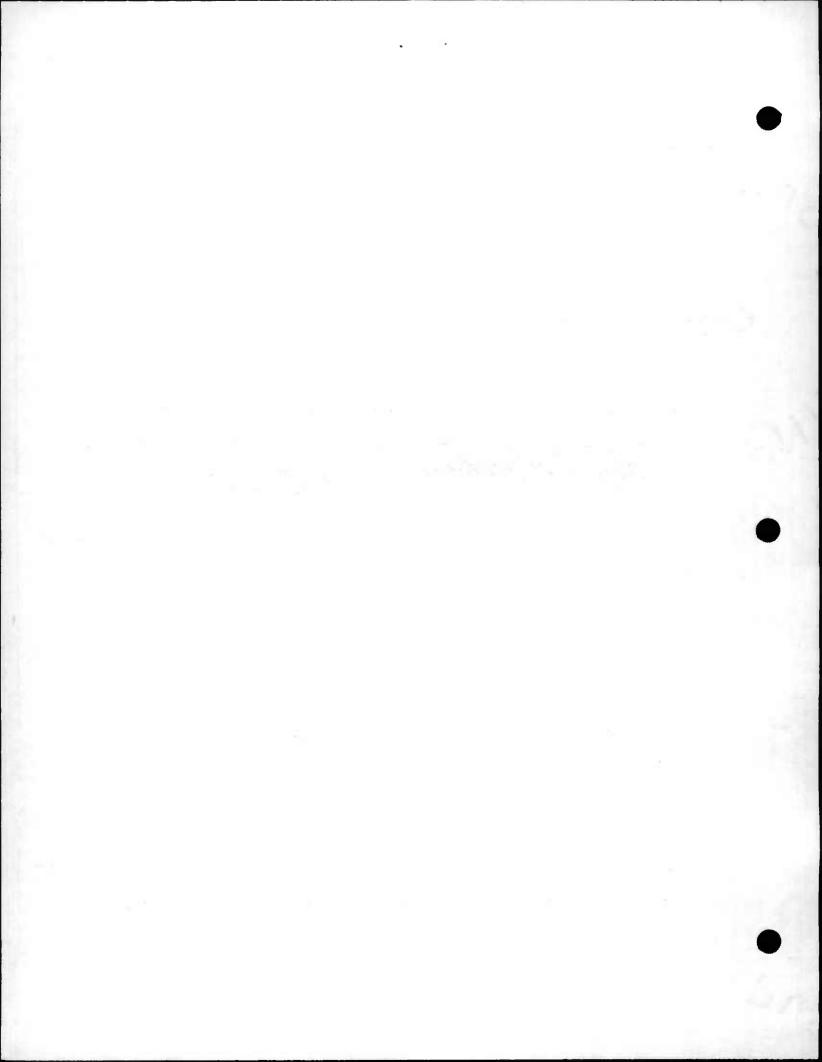


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page and within 70 hours after death, with the State Deat of Health and Mental Horizon principles in hours after death, with the State Deat of Health and Mental Horizon principles in hours after death, with the State Deat of Health and Mental Horizon principles.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete in find within 70 hours after death with the Grain has the other and Mental Horison and other the burial committee.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event,

				•						9	5	13648
	1 - FOR STATE REGISTRAR	STATE OF M	MARYLAND /	DEPAR ERTIF	RTMENT	OF H	IEALTH AN DEATH	D MEN	ITAL HYGI REG.			
	1. DECEDENT'S NAME (First, Middle, Last)					00.37	LED		DATE OF DEATH		O CYPAR	3. TIME OF OEATH
	INGEBORG	Т.				TY	LER	A	PRIL1	8",	1995	5:10 P
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER 24 HR	18. 7. D	ATE OF BIRTH	r1	Cour	INPLACE (State or Foreign
	575-36-6689	1 □ M 2 🙀 F	63	YRS.	MONTHS.	UNITE	HOOMS MIT	Ĵ	Month, Day, Yea une 25	, 193	31 Ge:	rmany
_	9a. FACILITY NAME (If not institution, give				100		OR LOCATION O	F DEATH			OUNTY OF	
P	63 GARNER AVE	VUE(RESI	DENCE)		WA	LDO	RF				CHARI	LES
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	ry		I 100 CIT	Y. TOWN C	OR LOCAT	TON					Lavana
E	Maryland C	harles		loc. Cit	.,	ldo						10d. INSIDE CITY LIMITS?
1	10e. STREET AND NUMBER				110		ZIP COOE			100		1 YES 2 NO
FUNERAL	63 Garner Avenue					101	2060	2		10g.		WHAT COUNTRY?
ᄬ	11. MARITAL STATUS	12 WAS DECEDEN	T EVED IN U.C. AD	MED	Lan	W 0 0 0 0 0						USA
BY FL	1 Never Married 2 Married 3 Divorced	IF VES CIVE WAR OR DATES								CE — American Indian, ek, White, atc.		
8	15. DECEDENT'S EO	UCATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16b, KIND OF	BUSINESS		WIIICE
COMPLETED	(Specify only highest gred Elementary/Secondary (0-12)	College (1-4 or 5	(Gi	ive kind of Do NOT u	work done (se retired.)	during mo	st of working					
립	8	Conege (I-C bi 3		ousev	vife				Ow	n Hor	ne.	
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	NAME (F	irst, Middle, Ma			*
	unknown								a Goeb		-,	
BE	19a. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS	(Street a	nd Number or Ru				Zin Code)	
2	William F. Tyler						enue, W					
	20s. METHOD OF DISPOSITION		20b. PLACE	_				_	DATE 20c			Town State
	1 Donation 5 Other (Specify)	novel from State	cemetery, cre	metory or o	ther place)	rans	Cem.		-21 C			
- 1	21. SIGNATURE OF FUNERAL SERVICE	CENSES		Lana	_		D ADDRESS OF	_		TIC I CC	JIII COM	, 1.10
		mato		n)			Funer			nc.		
_	Benjamin M.			8	_ W	aldo	orf. MD	206	04			
	23. PART I. Enter the diseesea, or shock, or heert failure.	List only one can	t coused the de	eth. Do	not enter	the mo	de of dying, i	such ea	cerdiec or re	spiratory	arrest,	Approximata
	IMMEDIATE CAUSE (Finel	July 5115 555	oc on odon ma	•								Intervel Batweer Onset and Deati
	disease or condition resulting in death)	a. CAN DUE TO	CER O) F	•	VO	ARY					2 /
		DUE TO	(OR AS A CONSEC	DUENCE O	F):							
Z	Securation, list conditions	b										
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
2	cause. Enter UNDERLYING CAUSE (Disease or injury	C										
1	that initiated eventa resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
EH	readiting in death) CAST	đ										
Ť. I	PART II. Other aignificent condition	ne contributing to	death but not re	eaulting	in the un	derivino	ceuse given	in Part	I. 24a. WAS	AN AUTOP	SY 24	b. WERE AUTOPSY FINDINGS
EDICAL							1,0-2-5010		PER	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 TYES	2 NO		OF DEATH?
M	DID TOBACCO USE CONT	DIDLITE TO CA	LICE OF DEA	TII VI	c \Box	10 F	LINICEDT	AIN. C	,			1 WES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	I KIBUTE TO CA			TN (Check of		UNCERT	AIN L	1		\perp	
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER							
1×S	1 YES 2 7. MANNER OF DEATH	1 Inpetient 2			4 🗆 Nun			_	Other (Specify)			
	1 Natural 5 Pending	28a. DATE OF (Month, D		28b. TIM	IE OF		RK?	28d.	DESCRIBE NO	W INJURY	OCCURED	
B	2 Accident Investigation	20 21 122 2					ES 2 NO					
ED	3 Suicide 6 Could not be 4 Nomicide datarmined	building,	F INJURY — At hor atc. (Specify)	me, ferm,	street, facto	ory, offica		281.	LOCATION (Str. City or Town, St	et and Nurr ate)	iber or Rural	Ploute Number,
E												
P.		SICIAN: To the best of										
COMPLET	one) 2 MEDICAL EXAMIN	ER: On the besis of a	amination end/or i	nvestigatio	on, in my o	pinion, d	eath occured at	the time,	data and place	, and due to	o the cause	(s) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICENSE	NUMBER		29d. 0	DATE SIGNE	D (Month, Day, Year)
00	Koull	41-	Man	~~			D-283			•	4-	19-97
임	30, NAME AND ADDRESS OF PERSON W	HO COMPLETED CALL	E OF DEATH (ITES	4 27) /5	Onine)		_ = = = = = = = = = = = = = = = = = = =					. ()



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

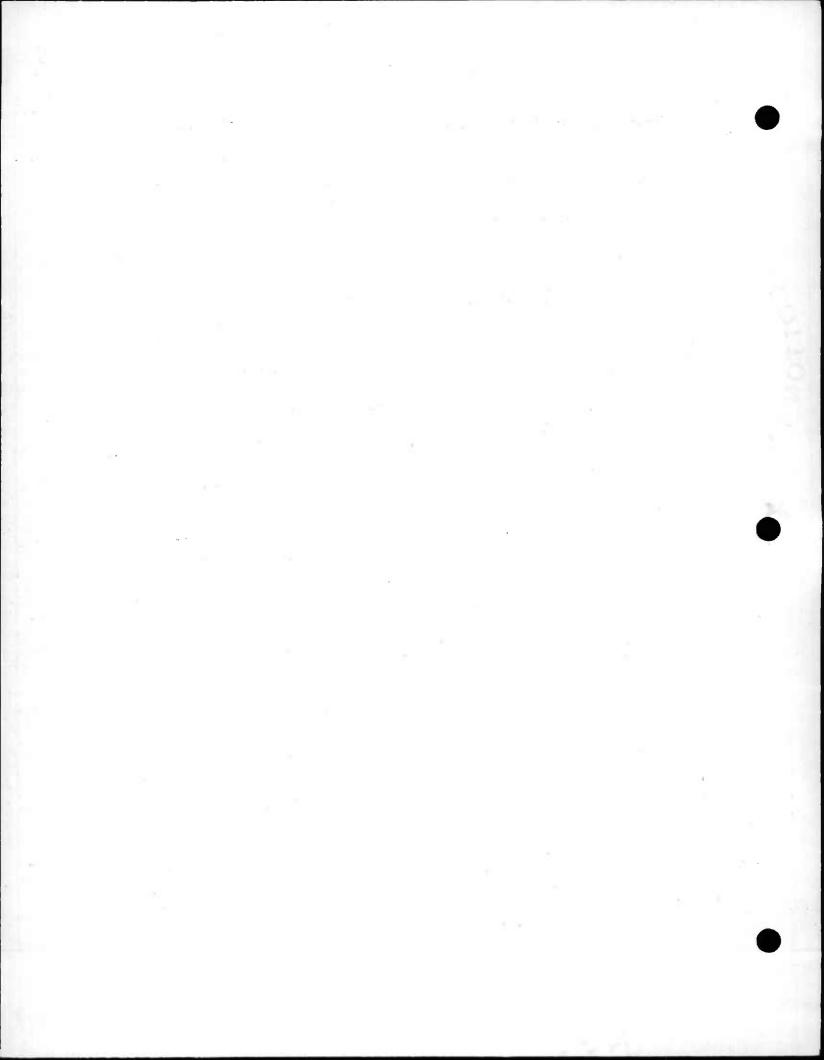
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed without their flours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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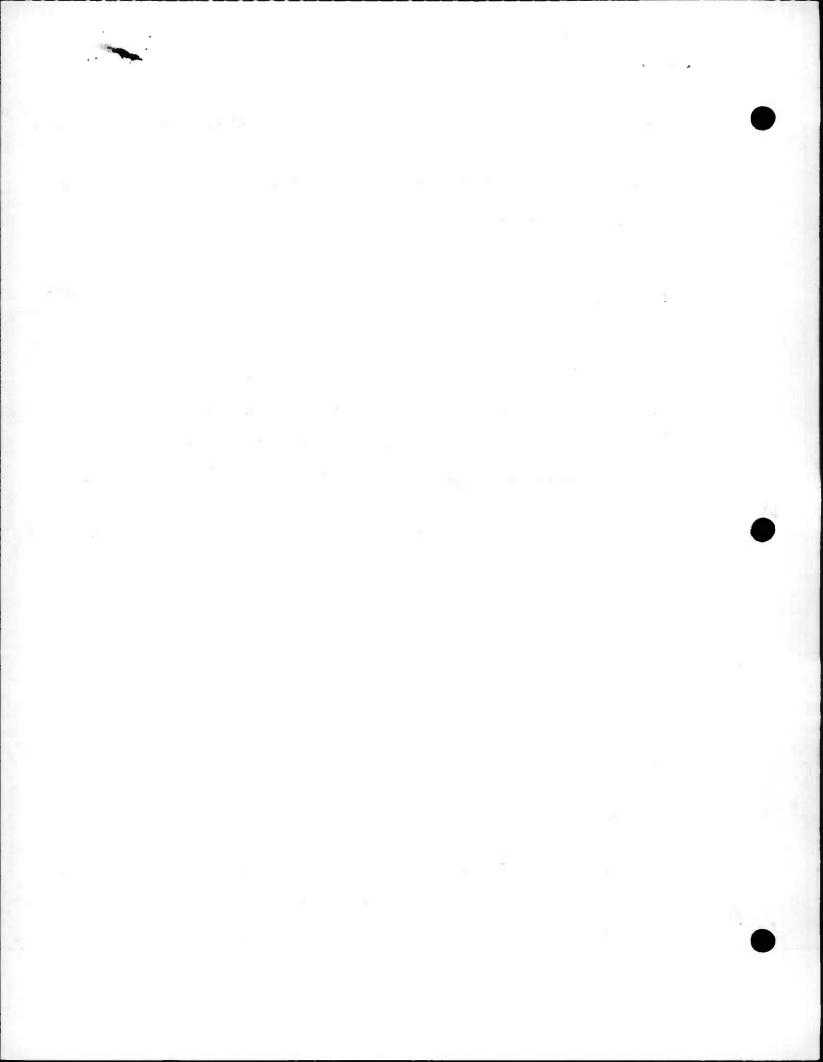
31. DATE FILED (Month, Dev.

												9	15	1364	19
	1 - STATE REGISTRAR	STATE OF I	MARYLAND C				HEALTH		MENT		YGIEN				
1 8	1. DECEDENT'B NAME (First, Middle, Last)								2. DA	TE OF D	EATH	AY		3. TIME OF DE	ATH
	Nicholas George 4. SOCIAL SECURITY NUMBER	Valltos,	Sr.							ril		1995	YEAR	10:42) P M
			, , , , , , , , , , , , , , , , , , , ,	et birthday)		R 1 YEAR	IF UNDER		7. DAT	TE OF B	RTH		8. BIRT	HPLACE (State or	
	579-20-3964	1XXM 2 □ F	70	YRS.	MONTHS	DAYS	HOURS	MIN.		onth, Day		1924	Wast	m nington,	D C
- 8	9e. FACILITY NAME (If not institution, give a	street and number)		-	9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	EATH		<u> </u>	9c. COI	UNTY OF	DEATH	_ D.C
CTOR	Prince George's F	Hospital	Center		Ch	ever	1y					Pri	nce (George's	3
BY FUNERAL DIRECTOR	Maryland Princ	land Prince George's Upper Marlboro										10d. INSIDE CIT LIMITS? 1 YES 2 X			
AL	10e. STREET AND NUMBER					1	of. ZIP COD	E				10g. CI	TIZEN OF	WHAT COUNTRY?	
ER	413 Kettering Dr	ive					2077	2				U.S	S.A.		
S	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.B. A	RMED	13.	. WAS DE	CENDENT C	OF HISPAN	NIC ORK	GIN? (Sp	ecify Yes		14. RAC	E — American Inc	flen.
7	1 Never Married 2 📉 Married	FORCES?	YES 2 AAR OR DATES	NO		If yes, I	pecify Cuba S 2 X NO	n, Mexica	in, Puerl	lo Rican,	etc.)		Blac	k, White, atc.	
	3 Widowed 4 Divorced	WW	II				O I (A NO	Specin	y.				Spec	White	
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. D	ECEDENT'S	USUAL C	OCCUPAT	ION lost of working		11	66. KINE	OF BU	SINESS/IN			
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5	446	B. Do NOT u	se retired.)	duning i	lost or worker	ng							
4	12			Res	stauı	rant	Owne	er		R	est	aura	nt		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTI	HER'S NA	ME (Firs	t, Middle,	Maiden	Sumeme)			
BE (George	Anatio	us				Va.	lchi	lik:	i	0	fano	S		
6	19a. INFORMANT'S NAME (Type/Print)		11	b. MAILING	ADDRES	S (Street	end Number	or Rural I	Route Nu	imber, Cit	y or Tow	n, State, Zi	ip Code)		
۲	Mary E. Valltos		1	13 K	ette	ring	g Dr.	Upp	er l	Mar1	bor	o, M	d. 2	0772	
	20e. METHOD OF DISPOSITION	ovel from State	20b. PLACE	ANDDATE	OF DISPO	SITION (leme of		D	АТЕ	20c. LO	CATION -	City or To	own, State	
	a Donatlog # Other (Specify)		Mary]	and /	Vete	rans	s Ceme	eter	$v \mid 4$	/13/	95	Che1	tenh	am,Mary	land
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENHE /	1	1	22.	. NAME /	AND ADDRES	SS OF FA	CILITY						
	· Dono	VIN	1.1	/		Geor	ge P	. Ka	las	Fur	era	I Ho	me	M4 207	15
	23 PART i Enter the discussion	0 00	un			<u>979(</u>) Uxoi	n Hi	TT :	Kα.	UXC	n n	ГТТ,	Md. 207	
	23. PART i. Enter the diseases, or a shock, or mant failure.	List only one cau	se on each lin	eath. Do i	not ente	r the m	oda of dyl	ing, suci	h aa ce	erdiac o	or reapi	ratory er	reat,	Approxin	
	iMMEDIATE CAUSE (Final disease or condition	1	. / -	_					,					Onset an	
	reaulting in death)	(Withing	ners	w (las	dis	Vas	ul	es	de	ne	se			
		DUE/TO	(OR AS A CONSE	OUENCE O	F):										
O	Sequentially list conditions,	b	100 10 1 00110												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE 10	(OR AS A CONSE	OUENCE O	F):										
일	CAUSE (Disease or Injury	C. DUE TO	(OR AS A CONSE	OHENCE OF	n.	-									
Ē	that initiated events resulting in death) LAST	502 10	(ON AS A COMSE	OUENCE U	r):										
Ü		d													
7	PART ii. Other aignificant condition	a contributing to	death but not	reaulting	In the u	nderlyi	ng cause g	jiven in	Part I.			AUTOPSY	240	. WERE AUTOPSY	FINDINGS
3										1	PERFOR			AVAILABLE PRIOF	
										1,0	169 2	Z-NO		DF DEATH?	3.0
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	PIRLITE TO CA	LISE OF DE	TH VE	:	NO F	7 LINIC	ERTAIN						1 TES 2	NO
¥	25. WAS CASE REFERRED TO MEDICAL	CIBOTE TO CA		CE OF DEAT				CKIAII	A IN	1					
잃	EXAMINER?	HOSPITAL:	ED/O-1-11-1		OTHE										
ΞH	27. MANNEB-OF OEATH	28e. DATE OF		28b. TIM	_		ne 5 □ Re JURY AT	sidence			**	JURY OC	- Augen		
	1 Natural 5 Pending	(Month, D		INJ	URY	W	ORK?	1110	28d. D	EŞCHIBE	: HOW II	NJURY OC	CURED		
B	2 Accident Investigation	28s BLACE O	E IN HIRV ALL				YES 2	NO							
	3 Suicide 6 Could not be 4 Homicide detarmined	building,	F INJURY — At he etc. (Specify)	ome, tarm, s	Hreet, fac	tory, offi	ce		28f. LC	ty or Tow	(Street e n, State)	nd Numbe	r or Rural I	Route Number,	
<u>u</u>	an- continue														
COMPLETED	(Check only 1 CERTIFYING PHYSI	CIAN: To the beat of	my knowledge, de	ath occum	d at the	time, dat	e end place,	end due	to the c	ause(s)	end men	ner ee ata	ted.		
ŏ	one) 2 MEDICAL EXAMINE	R: On the basis of a	xamination and/or	Investigatio	n, In my o	opinion,	death occur	ed at the	time, da	ite and p	lace, en	d due to t	he ceuse(e) end manner as	stated.
BEC	396. SHEMATURE AND TITLE OF CERTIFIEF	0.					29c. LICE	NSE NUM	IBER			29d. DAT	E SIGNED	(Month, Day, Year))
0 0	Mugusto ()	Coduff	resolu	M			2)2	12 2	30		J	alla.	110	1995	
2	an assure of the second second			-			EY C	-	10		/	1712	41	1///	

DHMH-18 Rev 1/89



		1 - STATE REGISTRAR	STATE OF MAR					EALTH DEAT			YGIENE EG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	n-	J'	h	in	050	n		2. DATE OF D	DEATH DAY		EAR	7:50 P
_			100	AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF 8 (Month, Day	NRTH r, Year)	0.	BIRTHPLA Country)	CE (State or Foreign
. 3 should	NO NO	90. FACILITY NAME (If not institution, give street Dorchester Ge		ospita	a1			n LOCATIO	ON OF DEA			c. COUNTY	OF DEATH	
permit. Pages 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	chester			Y, TOWN (OR LOCATI						10d	1. INSIDE CITY LIMITS?
SI	AL	10e. STREET AND NUMBER 909 ROS1		101. ZIP CODE						1	10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
215-0020 attending physician. se as the bunal-transit	BY FUNER	-	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR C	ES 2 NO	ED		It yee, spe	ENDENT O	F HISPANIC	ORIGIN? (Sp Puerto Ricen			RACE — A	American Indian, hite, etc. White
21. al or us	PLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	TION impleted) College (1-4 or 5+)	(Give	De. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker						TRY			
/LA by the be det	BE COMPL	17. FATHER'S NAME (First, Middle, Last) Sherma	an Rob	inson				18. MOTH		E (First, Middle 1221		name) Jones	5	
	TO B	19e. INFORMANT'S NAME (Type/Print) Mrs. Phyllis V	Valker							ute Number, C				
ALTIMORE, r leath. Page 6 may be it funeral director, page 5		20a. METHOD OF DISPOSITION XIXBurlel 2 Cremetion 3 Remov 4 Donetion 5 Other (Specify)		20b. PLACE AN cemetery, crem	DDATEC	of dispos ther plece) Cer	Memo	ne of Oria	1 Pa	rk 4	20c. LOCAT	ciny — city	or Town,	e Md.
0 = 0	- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lexantle Alberta J. 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613												
with hours at mpletely filled in by cremation, or remover, the medical		23. PART I. Enter the diseasee, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory erreet, ehock, or heart feliure. List only one cause on each line. Approximate interval Bet											Approximate Intervel Between Onaet and Daeth	
certificate be execute right of the physician and or hygiene prior to burian of the transmatic	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												
RDS, at the de by the a and Ment	MEDICAL CE	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WE AM CONTRIBUTION OF THE PROPERTY										RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
ITAL RECO N. The law requires the ficate has been signed State Dept. of Health iftem 23 shows an	PHYSICIAN: MI	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEAT	_			UNC	ERTAIN				1 [YES 2 NO
OF VITAL PHYSICIAN: The law this certificate has with the State Dept ked, or item 23	YSIC	1 YES 2 NO	IOSPITAL: Vinpetient 2 - ER/	Outpatient 3	DOA	OTHER 4 - Nun		5 🗆 Res	sidence 6	Other (Spe	ocify)			
VISION OF VI ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 128 is marked, or it	ВУ РН	27. MANNER OF DEATH t Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJU (Month, Day, Ye.	ar)	286. TIME INJ	M		RY AT IK? ES 2 [NO	ead. DESCRIB				
DIVISION UR ATTENDING P DIRECTOR: After t hours after death item 28 is mar	ETED.	3 Suicide 8 Could not be determined	28e. PLACE OF INJ building, etc. (Specify)	e, ferm, s	treet, fect	ory, office			28f. LOCATION City or Tov	(Street end vn, Stale)	Number or F	Rural Ploute	Number,
TO THE HOSPITAL D TO THE FUNERAL D be filed within 72 he IMPORTANT: If Ite	COMPL	(Check only one) 2 MEDICAL EXAMINER:	N: To the beat of my k On the basis of examin										ouse(e) end	menner es stated.
TO THE P TO THE P be filed w	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER		_				29c. LICE	(ST	ER G f	29	DATE SIG	GNED (Mor	nth, Day, Year)
~		30. NAME AND ADDRESS OF PERSON WHO (M - S - S G + B + C) 31. DATE FILED (Month, Day, Year)		9. 1			ora	St.	, Ca	mbri	dge M	1D 21	1613	
		APR 2 4 1995	Jalia Daws	lear Rand	all									



3. TIME OF DEATH

1:00 A

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc. Specify: White

1XXYES 2 NO

Approximata

Onset and Death

well

8. BIRTHPLACE (State or Foreign

Maryland

Dorchester

10g. CITIZEN OF WHAT COUNTRY?

USA

Cambridge. Md.

9c. COUNTY OF OEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH Jeanne Winterbottom Wright April 22, 1995 YEAR 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
April 23, IF UNDER 24 HRS. IF UNDER 1 YEAR 220-46-1460 1 - M XX F 79 DAYS HOURS VRS Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF GEATN DIRECTOR Dorchester General Hospital Cambridge RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Dorchester Cambridge permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 115 Mill Street 21613 funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEOENT EVER IN U.S. ARMED FORCES? 1 YES XX NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Married BY 3 Widowed 4 Divorced 0 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OECEOENT'S EQUICATION 18b. KIND OF BUSINESS/INQUISTRY COMPLET ege (1-4 or 5+) 5+ /Secondary (0-12) 11 Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) W. Grason Winterbottom notified at Nannie Davis BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hubert H. Wright IV P.O. Box 110 Cambridge, Maryland 21613 hours after death. Page 6 may be must be 20a. METNOO OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Christ Episcopal Churchyard 4/25 4 Donation 5 Other (Specify) examiner 21. SIGNATURE A FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Thomas Funeral Home 700 Locust st. Cambridge, Maryland 21613 the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. tomer the medical 23. PART | Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory screet, shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 the death certificate be executed CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t that initiated events reaulting in death) LAST 6 has been signed by the Dept. of Health and Mn 23 shows any inji MEDICAL resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) DIRECTOR: After this certificate I hours after death with the State Item 28 is marked, or Item OTHER: 1 TES 2 NO itlent 2 ER/Outpatient 3 DOA Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? Hatural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Sulcide COMPLETED 6 Could not be ₹ 58 ₽ 4 Nomicide HOSPITAL OR 29e. CERTIFIER

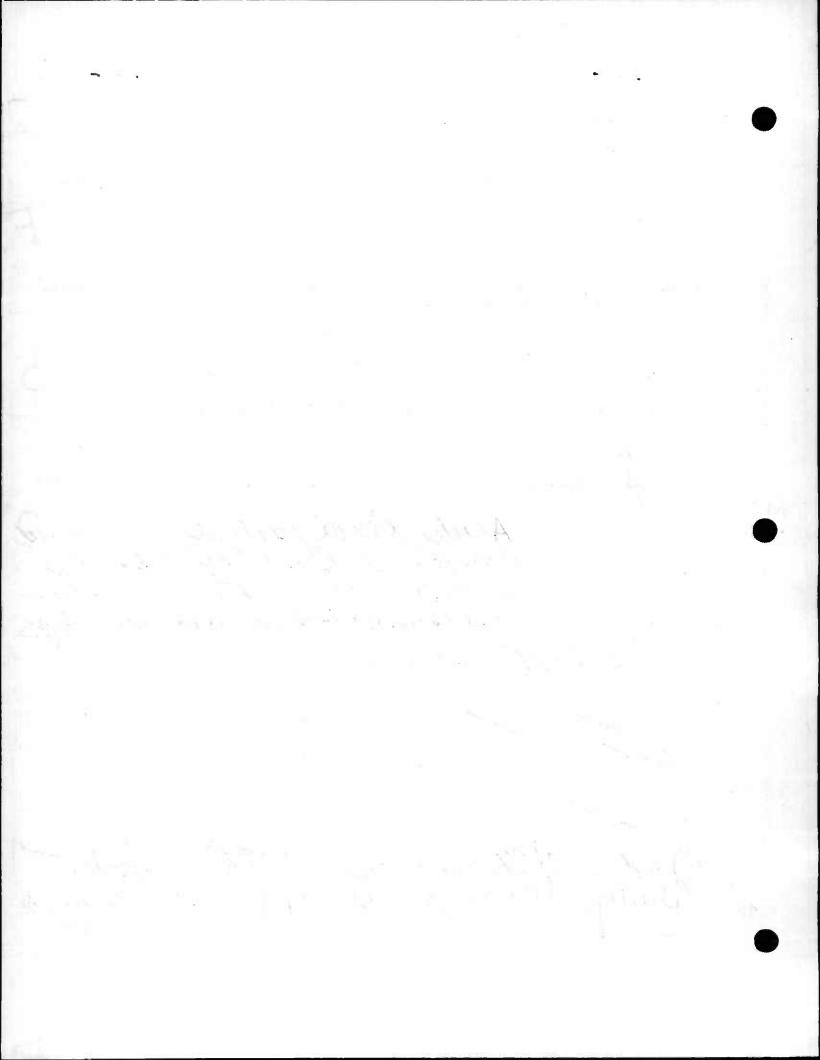
2 MEDICAL EXAMINER: On the

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

24b. WERE AUTOPSY FINDS MARLABLE PRIOR TO 24s. WAS AN ANTOPSY COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO 28d. OESCRIBE NOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner as attated. beele of exemination end/or investigation, in my opinion, death occured at the time, date end piece, end due LICENSE NUN h. Clay Month

FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IT

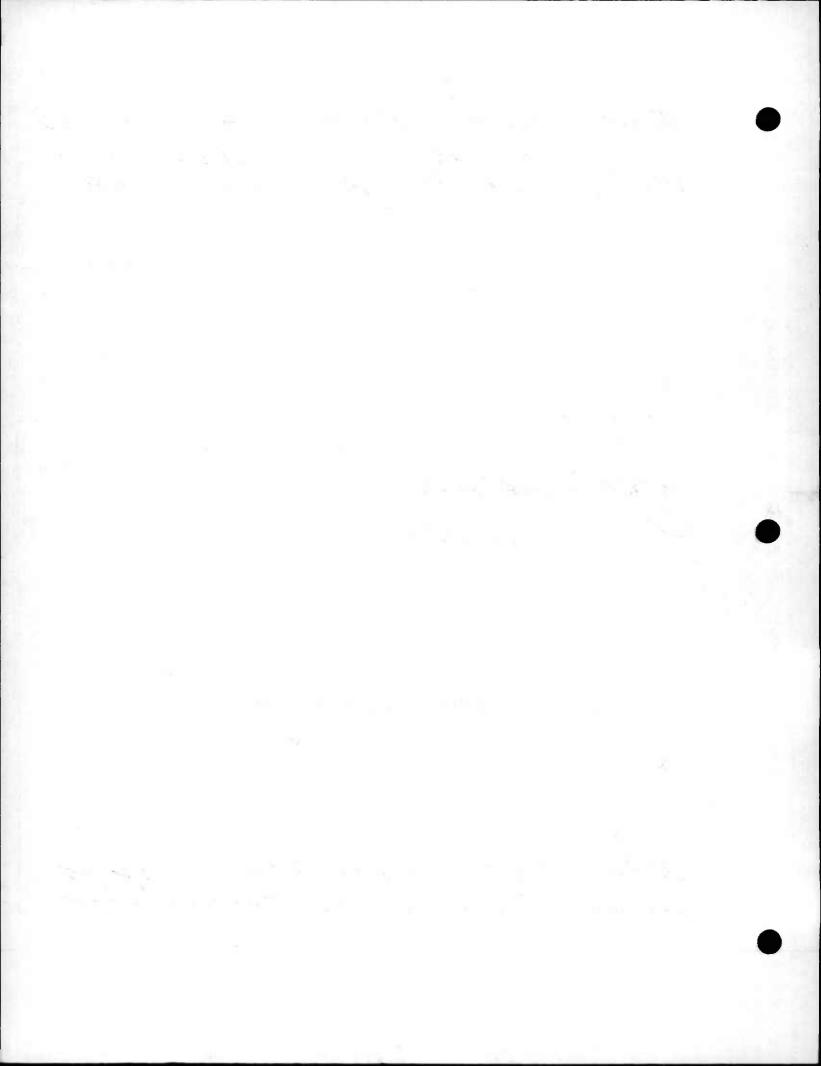


		FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA	MENT OF H	EALTH AND I	MENTA	L HYGIENI	E 4-18	-95	9:36AM
		1. DECEDENT'S NAME (First, Middle, Last)	Julius Nap			231	2. DATE	OF DEATH	8 9	3. 5	TIME OF DEATH
			M 2 F		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH	3.	Country)	CE (State or Foreign
3 should	E C	90. FACILITY NAME (If not institution, give stree	AShington	0-	o. CITY, TOWN O	R LOCATION OF DE	EATH /	144/1	9c. COUNTY		
88 1, 2,	RECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	A DA TRE TO		OWN OR LOCAT	ION I C				1 10	d. INSIDE CITY
nit. Pages	₫	MD Anne	Arundel		Annapo	olis					LIMITS? YES 2 NO
sit permit.	FUNERAL	100. STREET AND NUMBER 29 West Washingto	n Street		101.	21401					T COUNTRY?
DZU physician. burial-transit	UNE	11. MARITAL STATUS	2. WAS DECEOENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	NIC ORIGI	1? (Specify Yes			American Indien,
	B≺	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			Z NO Specify		Hicen, etc.)		Speaker	White
r attend use as	TED	15. DECEOENT'S EDUCAT (Specify only highest grade cor		18a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mos		160	. KIND OF BUS	INESS/INDUS	TRY	
the hospital or attending detached for use as the once.	COMPLETED	Elementary/Secondary (0-12) (0-12)	College (1-4 or 5+)	Contra				Ship	p Buil	der	
	E CO	17. FATHER'S NAME (First, Middle, Lest) UNKNOWN				16. MOTHER'S NA	ME (First,		Sumame)		
MAHY retained by 5 should by notified at	TO BE	19a, INFORMANT'S NAME (Type/Print)				nd Number or Rural i	Route Num	ber, City or Town		de)	
ay be		Karl C. Wehr 20 METHOD OF DISPOSITION 19 Burlel 2 Cremation 3 Remova	206.	52 Get		ourt Anna	I logs		21403 PATION — City	or Town.	State
r IMORE, . Page 6 may be ral director, page		4 Donation 5 Other (Special)		edar Brut	f Ceme t	ery 4/2	25/95	Ann	apolis	, Ma	ryland
death r death le fune al.		21. SIGHATURE OF FUNERAL BERVICE DCEN	SEE SEE		22. NAME AND ADDRESS OF FACILITY Ohn M. Taylor Funeral Ho 147 Duke of Gloucester St. Annapolis, MD						
filled in by the lon, or removal		23. PART I. Enter the diseasea, or con ahock, or heart fellure. Lis	npilcations thet caused it only one ceuee on ee	the deeth. Do not ch line.	anter the mod	da of dying, auc	h as car	diac or reapir	ratory arrest	4	Approximata Interval Between
E 6 €		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ASC	UD							Onset and Death
9 5 5 6		a	DUE TO (OR AS A	CONSEQUENCE OF):							
and o bur	TION	Sequantially list conditiona, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
e placat	RTIFICATIO	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					-		
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- E - E -	MEDIC							1 YES 2	4.4	CO	MPLETION DF CAUSE DEATH?
St. of		DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF E	DEATH Y	ES NO	_			1 [YES 2 NO
E ste h	ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:			ACE OF DEATH (Ch		na)			
SICIAN: The certificate the the State d, or item	PHYSICI	1 YES 2 NO 1 27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O		URY AT		r (Specify) SCRIBE HOW IN	JURY OCCUR	ED	
DING PHYS After this death with	ВУР	Natural 5 Pending Investigation	(Month, Day, Year)	INJURY	M 1 🗆 Y	RK? (ES 2 NO					
TTEN TOR:	ETED	3 Suicida 8 Could not be determined	28e. PLACE OF INJURY - building, atc. (Specif	— At home, ferm, atre-	et, fectory, office			ATION (Street a or Town, Stete)	nd Number or i	Rural Route	Number,
4 7 2 E	COMPL	1 A A	N: To the beat of my knowle							luse(e) en	d menner en stated,
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	296 SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHAT OF	Lyms	Dep	uty	29c, LICENSE NUI	MBER 605	74	▶ 4/	MED (Mo	195
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 95 Ames DAML Ke 1050 4. SOCIAL SECURITY NUMBER 5. SEX 8. BIRTNPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, You 1 1 M 2 | F HOURS YRS. 219-22-3803 ¥ 67 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 401 CA DIRECTOR 51. pe INA RESIDENCE OF DECEDENT 10b. COUNTY 10d. INSIDE CITY Maryland 1 YES 2 NO <u> Anne Arundel</u> <u>Annapolis</u> FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1401 Cape St. Claire Road 21401 U.S.A. within thours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. RACE — American Indien, Black, Whita, atc. 1 Never Married 2 Married 1 TYES 2X XNO Specify: Specify: BY ₩Widowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 +Carpenter Construction once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) page 5 should be notified at BE Holland Walker Lillian Walker 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 James Walker, Hilltop Ln. Annapolis, MD 21403 pe 20a. METNOD OF DISPOSITION
1 Burlat 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, 4 Donation 5 Other (Specify) 4-24-1995 Brooklyn, Hill Cemeterv traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 21146 Ritchie Hwy Severna Park, completely filled in by the 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart fellure. List only one cause on each line. Approximete interval Between Onset and Death cremation, or IMMEDIATE CAUSE (Finel disease or condition___ SCUD reculting in deeth) DUE TO (OR AS A CONSEQUENCE OF): executed bunal, CERTIFICATION DIRECTOR: After this certificate has been signed by the attending physician and hours after death with the State Dept. of Health and Mental Hygiene prior to burn Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING a other t CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST 0 PART II. Other aignificent conditions contributing to death but not requiring in the undarlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE requires that any 1 TYES 2 NO OF DEATH? shows 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Bar{\cup} \) NO \(\Bar{\cup} \) HOSPITAL OR ATTENDING PHYSICIAN; The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 A Boalde 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 1 YES 2 NO BY 28s. PLACE OF INJURY — At home, farm, strast, factory, office building, atc. (Specify) 28 is r 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide If Item 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and menner ea stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 ho 2 MEDICAL EXAMINER: On the besis of axe SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 띪 courty 9 AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) ON es merica 1m 32. REGISTRAR'S SIGNATURE

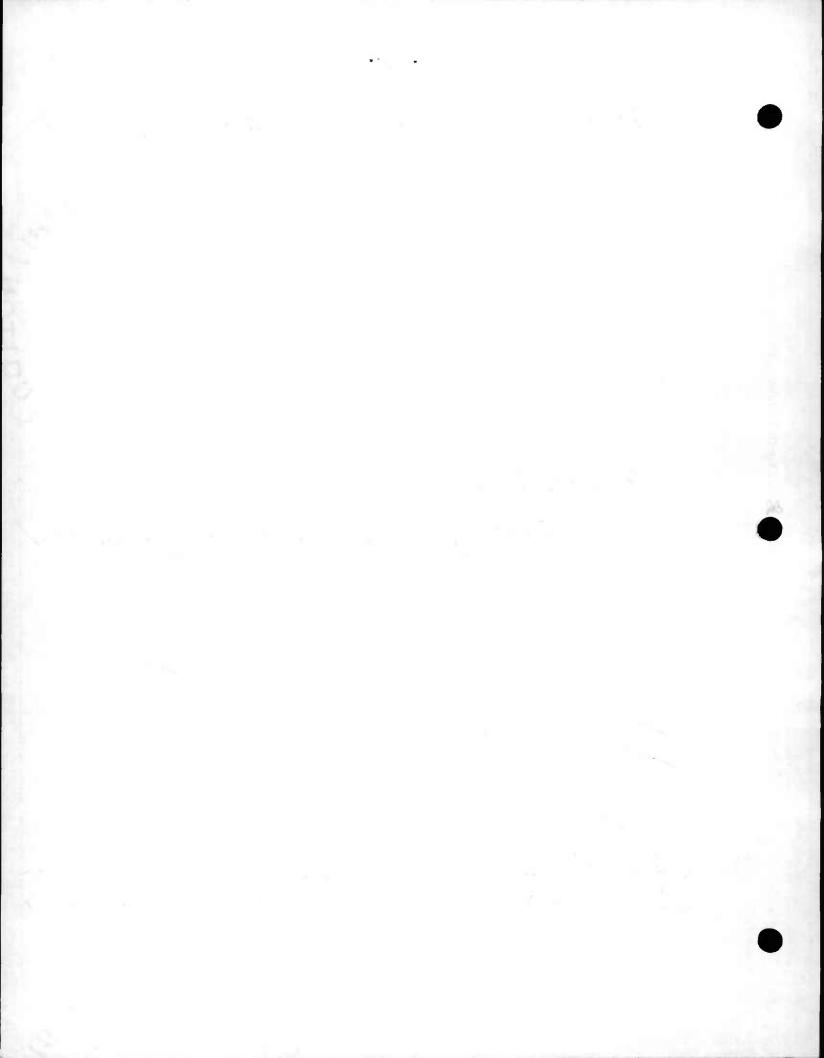
his Stevelson Reveal



BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physici. DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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	1. DECEDENT'S NAME (First	n, Middle, Last)		4	U, 1/e;	++		,	DATE OF D	2 9AY 1	a a YEA	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMI	BER	5. SEX	6. AGE (In vrs	s. last birthday)	IF UNDER 1 Y	FAR IS IMPO	R 24 HRS.	I DATE OF B	IOTU /	170	OTHER 405 (Out of 5	
	400-56-297	77	1 🗆 M 2 🔀 F	MONTHS DAYS HOURS MIN.					(Month, Day,	Year)	Co	RTHPLACE (State or Foreign ountry)	
	9a. FACILITY NAME (If not in			54					April			Kentucky	
l cc				9b. CITY, TOWN O						9c. 0	COUNTY O	F DEATH	
2	Fort Washi	ingtor	<u>n Medica</u>	al Cer	nter	Fo.	rt Wa	shind	gton	Pı	rinc	e George	
DIRECTOR	10a. STATE	10b. COUNTY	Υ		10c, CITY,	TOWN OR L	OCATION					10d. INSIDE CITY	
=	Maryland	Char	100					a				LIMITS?	
	10e. STREET AND NUMBER		res	Indian Head						1XXyES 2			
FUNERAL	The second of the second		21									OF WHAT COUNTRY?	
쀨	24 Greenw	vood F					206				J.S.	Α.	
5	11. MARITAL STATUS	Married	12. WAS DECEDEN FORCES? 1	YES 2X	NO N	13. WAS	B Specify Cub	OF HISPANIC an, Mexican,	ORIGIN? (Sp. Puerto Rican.	ecify Yes or No	- 14. R	ACE — American Indian, llack, White, etc.	
À	3 Widowed 4 Dive		IF YES, GIVE W	AR OR DATES	7		YES 2 NO			,		pecify:	
ED			<u> </u>									White	
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۳ ا	Elemantary/Secondary (0	0-12)	College (1-4 or 5 i	+)		lee kind of work done during most of working Do NOT use retired.)							
₹	12				Homem	memaker Her Home							
COMPLET	17. FATHER'S NAME (First, M	CHILDRE					18. MO1	HER'S NAME	E (First, Middle,	, Malden Surnan	ne)		
ш	Earl	Alery	Shup	e			M:	innie	Ann	Swaf	for	đ	
0	19a. INFORMANT'S NAME (7				19b. MAILING	DDRESS (St				ty or Town, State			
2	Charles D	onald	Willet	t							ĺ		
	Charles Donald Willett Same as #10 20a. METHOD OF DISPOSITION 1 Buriel 20 Premation 3 Removal from State Completer, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of Completer, cremetory or other place)											Town State	
	1 ☐ Burial 2/☐/Crematic 4 ☐ Donation 5 ☐ Other	on 3 - Remo	oval from State	cemetery	cremetory or oth	er placal			1				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
ĝ.	Williams Funeral Home, P.A.												
	M00668 Rt. 225 & Glymont Rd, Indian Head, M												
	disease or condition resulting in death)	→ ×	Drabetic DUE TO	huses)	HOWBELL SECULIARIES	arte	un	leril	ice ap	dered	lone	Interval Betwo	
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D BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list condition if any, leading to immediate sequences. Enter UNDERLYI CAUSE (Disease or injusted in the injusted sequences of the injus	lons, diste ling in the long line in the	DUE TO DUE TO	(OR AS A CON (O	EATH YES LACE OF DEATH 28b. TIME INJUI	the under (Check only THER: DI Nursing OF M 1 set, tectory, at the time, In my opinion	dying cause UNC one) Home 5 R NUURY AT WORK? YES 2 { office date and place on, death occu	given in Paragraphic CERTAIN Sesidence 8 2 NO 2 2 2 2 2 2 2 2 2 2 2 2 2	Other (Special City or Tow the cause(a) ne, date and p	WAS AN AUTOP PERFORMED? YES 2 MO city) E HOW INJURY (Street and Num n, State) and manner as	OCCURED	Onset and Do 24b. WERE AUTOPSY FINDIN AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO No Prior Number, No	



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH April 1995 Robert Darrell Whittaker 8:15P M 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTNPLACE (State or Foreign DAYS HOURS 1 3M 2 F 315-54-1436 45 949 Indiana Nov Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR 5012 Manor Court Oxon Hill Prince George's 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION ā Maryland Prince George's Oxon Hill 1 X YES 2 | NO funeral director, page 5 should be detached for use as the burial-transit permit. 10e, STREET AND NUMBE FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5012 Manor Court 20745 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ΒY 1 TYES 2 NO Specify. 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Minister Years Private notified at once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Earl Whittaker BE Edith E. Berry 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 Manor Court 2 Sandra Whittaker/Wife Hi 11 20745 OxonMarvland pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE 1 Burtai 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harmony Memorial Park Landover, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home the 1 7474 Landover Road, Landover, MD cremation, or removal 20785 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, the attending physician and completely filled in by it Mental Hygiene prior to burial, cremation, or remo Approximate ahock, or heert fallure. List only one cause on each line Intervel Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in deeth) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO AS A CONSEQUENCELOF): a traumatic CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST Injury. PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Health and 1 TYES OF DEATH? 1 YES 2 NO t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO DE UNCERTAIN I has be Dept. THE HOSPITAL DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only or certificate h HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Nome 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF marked, 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED DIRECTOR; After this of hours after death with 1 Natural Pending Investigation 1 YES 2 NO ΒY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 649 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide tem 29a, CERTIFIER 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as ateted. (Check only one) FUNERAL within 72 h IMPORTANT: II 2 MEDICAL investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) end menner as stated. TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGN THE I BE nth. De 2 2

WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

adunm

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26 PS

32. REGISTRAR'S SIGNATURE STUDIES ROUGH RO

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Ventat

31. DATE FILED (Month, Day, Year,



REG. NO

	E.	R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit per er death with the State Dept. of Health and Mertal Hyglene prior to burial, cremation, or removal.	
020	physicia	burial-t	
215-0	ittending	e as the	
212	ortal or a	d for us	
ANE	the hos	detache	
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0	ithin 24	letely fill emation	
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O. B	ertificat	ing phys rgiene p	
S, P.	death c	e attend lental Hy	
ORD	that the	bd by th	
ECC	equires	en signe of Healt	
SION OF VITAL RECORDS, P.O. BOX 68760	NOING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	R: After this certificate has been signed by the attending physician and completely filled in by the fi er death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	
VIT	CIAN: TI	artificate the State	
107	PHYSI	r this cu	
0	NOIN	R. Afte er deat	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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FOR STATE REGISTRAR

All Berger MD

31. DATE FILED (Month, Day, Year)

APR 11 1995

36. NAME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

38 REGISTRAR'S SIGNATURE

1 -

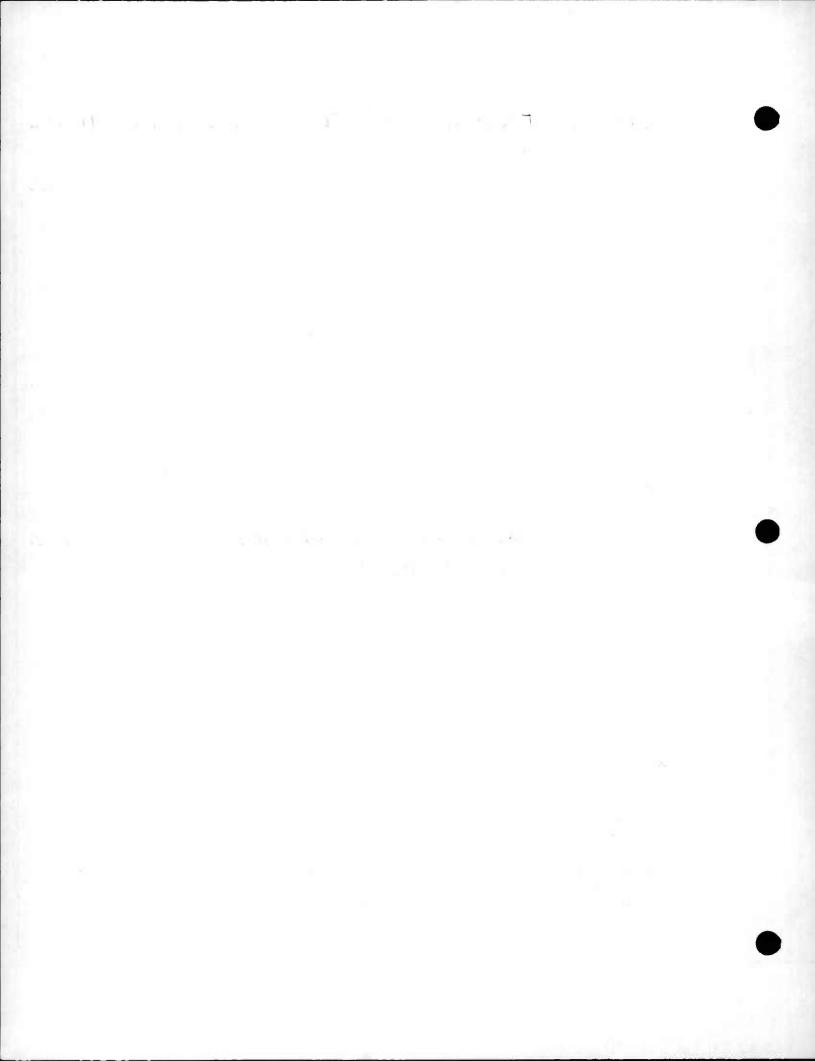
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 995 BERNARD WHITFIELD TAMES 11:30 APRIL 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
DEC . 27, 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 M M 2 - F WASHINGTON, DC 578-46-7470 61 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN PRINCE GEORGES DIRECTOR 112 ESSENTON DRIVE UPPER MARLBORO 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE'S UPPER MARLBORO 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 112 ESSENTON DRIVE 20772 USA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XXYES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify, Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES
AIR FORCE - 20 YEARS ΒY Specify: BLACK 3 Wildowed 4 Divorced 18a, DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) (GOVT.) Elementary/Secondary (0-12) College (1-4 or 5+) MASTER MECHANIC US POSTAL SERVICE 4 YEARS notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) JOHN WHITFIELD LILLIE MAE GRISWALD **BE** 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 PATRICIA WHITFIELD/ WIFE 112 ESSENTON DRIVE UPPER MARLBORO, MD20772 pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 N Burial 2 Cremation 3 🗆 R ARLINGTON NATIONAL CEM. 4-13 ARLINGTON, VIRGINIA Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACHTY FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 Muccell medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onact and Death** the disease or condition resulting in death) A CUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF): event. MINUTES OBONARY HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION YEARS Sequentially list conditions. if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE PERFORMED? any 1 TYES 2 T NO OF DEATH? shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) The The HOSPITAL OTHER 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Nome 5 Rasidence 8 - Other (Specify) 9 27 MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide .00 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be TO THE FUNERAL DIRECTOR:
TO THE FUNERAL DIRECTOR:
To filed within 72 hours after a important; if item 28 is 4 Nomicide determined 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. (Check only one) 2 XMEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B

J. BERGER MD # 205,7720 WISCONSWAVE BeThesda Md 20814

D25925

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

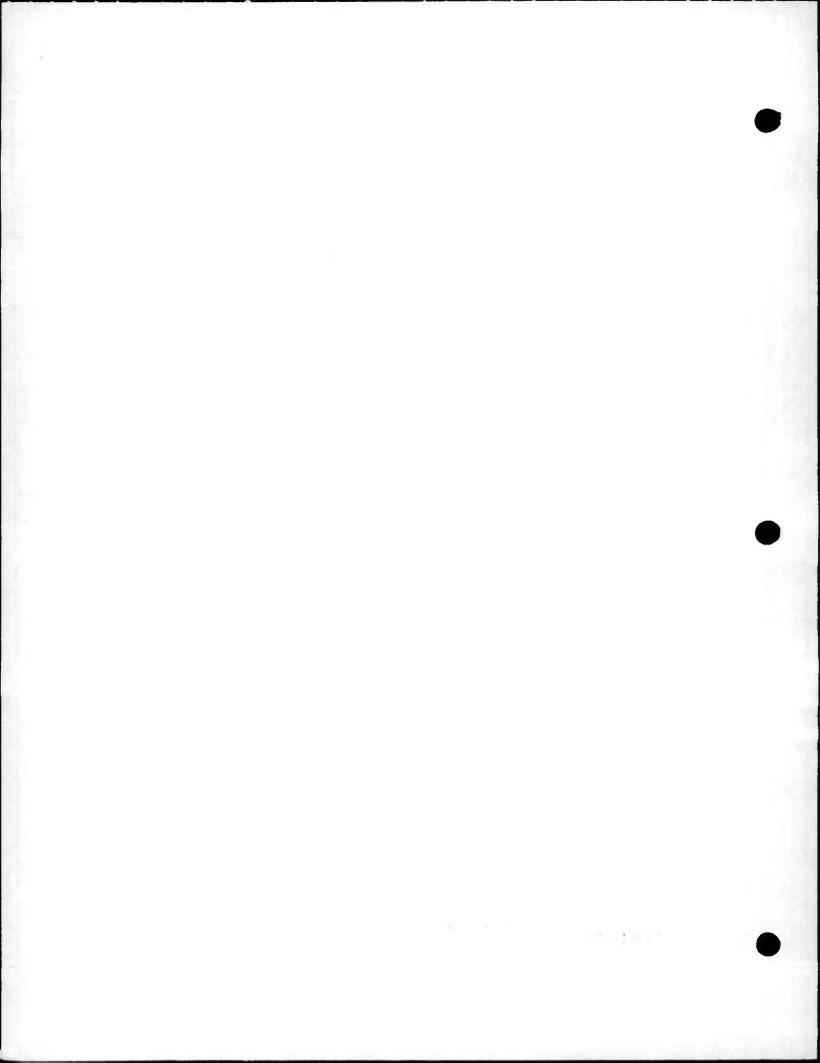
CERTIFICATE OF DEATH



Dr. Asif Qadri, 31. DATE FILED (Month, Day, Year)

							90	13001
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF	HEALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Patrick J.	Wenzel				MONTH D		TEAR
	4. SOCIAL SECURITY HUMBER	5. SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	April 8		BIRTHPLACE (State or Foreign
	218-09-9474	1 KM 2 F 7	7 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)
	9e. FACILITY NAME (# not institution, give stre		,	Ob OITY TOWN	OR LOCATION OF DE	March 1/,		ashington, D.C
œ	8501 48th Avenue	or and namedy				EATH		Y OF DEATH
1 6	RESIDENCE OF DECEDENT			Colleg	e Park		Princ	e George's
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TIOH			10d. IHSIDE CITY
ä	Maryland Prince	e George's		Colleg	e Park			LIMITS?
A A	10e. STREET AND HUMBER				H. ZIP CODE		10g. CITIZE	H OF WHAT COUNTRY?
FUNERAL	8501 48th Avenue				20740		U.S.	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			IIC ORIGIN? (Specify Ye		I. RACE — American Indian,
	1 Hever Married 2 Married	FORCES? 1 X YES IF YES, GIVE WAR OR DAT		If yes, s	pecify Cuban, Maxical S 2 X HO Specify	n, Puarto Rican, atc.)		Black, White, elc.
B	3 🔀 Widowed 4 🗌 Divorced	WW II		1 1 16	S 2 K HO Specify	<i>/</i> :		Specify: White
	15. DECEOENT'S EDUCA (Specify only highest grade co	TION Ompointed	18a. DECEDENT'S	USUAL OCCUPATI	ЮН	16b. KIND OF BU	SINESS/IHDUS	
🗓		College (1-4 or 5 +)	life. Do NOT us	work done during m se retired.)	ost of working			
를	10		Carpent	er		Privat	e	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAI	ME (First, Middle, Maiden	Sumame)	
BE	Joseph Wenzel				Catherin	ne Schatz		
	19a. IHFORMANT'S HAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Tow	n, State, Zip Co	ode)
임	John F. Wenzel					nd, Maryla		777
	20a. METHOD OF DISPOSITION	20b. f	N ACEAHODATE	OF DISBOSITION (M	lama of			
1 1	1 № Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	al from State Geme	tery, cremetory or o	ther place)	Cem. 4/1	.3/95 Ade	lnhi l	Maryland
1 1	21. SIGNATURE OF FUNERAL SERVICE LICEN	HSEE		22. NAME A	NO ADDRESS OF FAC	CILITY		
1 /	> (Helle Day 2	< ROOD	1	Franc	is Gasch'	s Sons Fu	neral 1	Home, P.A.
Н	and the second of	· Dea		4739	Baltimore	Ave. Hva	ttsvil	le. MD 20781
	23. PART I. Enter the diseases, or cor shock, or heert fellure. Lie	mplications that caused et only one cause on ear	the deeth. Do r ch iine.	not enter the mo	ode of dying, auch	h aa cerdiac or reep	iratory errae	t, Approximete Interval Between
	iMMEDIATE CAUSE (Final disease or condition	MAIL	C II O A	IT C	0011	0 4000	Tun	
	resulting in death)	MALLIO OUE TO (OR AS A C	SNA	01	412011	CARIL	Jian.	A I yam
				1.				0
3	Sequentially list conditions, b.		ESTIV		KDIOM	YOPATH	17.	8 yes
Ĕ	if any, laading to immediate	OUE TO (OR AS A C	CONSEQUENCE OF	F):		~		0
2	CAUSE (Disease or Injury	D115 70 100 10 10 1						
E	that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):				
CERTIFICATION	d.							
	PART II. Other eignificant conditions	contributing to death but	t not resulting i	in the undariyin	g causa given in i	Part I. 24s. WAS AH	AUTOPSY	24b. WERE AUTOPSY FIHDINGS
MEDICA					3 2 5 5 5 5 5 7 1 9	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
8	X					1 _ YES 2	□ но	OF DEATH?
Σ	DID TOBACCO USE CONTRI	DUITE TO CAUCE OF	DEATH VE	r El No E	7 111 10555			1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)		<u> </u>		
I I	EXAMINER?	HOSPITAL:		OTHER:	A /			
₹ S	1 YES 2 NO 1	Inpatient 2 ER/Outpat		4 - Nursing Hon		6 Other (Specify)		
	1 Netural 5 Pending	28a. DATE OF IHJURY (Month, Day, Year)	286. TIM	URY WO	JURY AT DRK?	28d. OEŞCRIBE HOW I	NJURY OCCUR	ED
B	2 Accident Investigation	24- 51 405 65 11 11 11			YES 2 NO			
8	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY - building, atc. (Specify	- At home, farm, s	streel, factory, offic	**	28f. LOCATION (Street a City or Town, State)	and Number or i	Rural Route Number,
COMPLETED	29a. CERTIFIER (Check only one)	AH: To the best of my knowled	dge, death occurre	ed at the time, date	and place, and due	to the cause(a) and mar	ner se stated.	
S I	2 MEDICAL EXAMINER:	On the basis of examination	and/or investigatio	n, in my opinion, o	leath occured at the I	lime, data and place, an	d due to the c	ause(a) and menner as stated.
ш	29b. SIGHATURE AND TITLE OF CERTIFIER	KOU			29c. LICENSE NUM	BER	29d, DATE SI	IGNED (Month, Day, Year)
0		Mann			1229	10		PRIL 10,1995
일	30. HAME AHD ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type,	Print)	1-1		///	121-1011113

4700 Berwyn House Road, #100, College Park, MD
32. REGISTRAR'S SIGNATURE

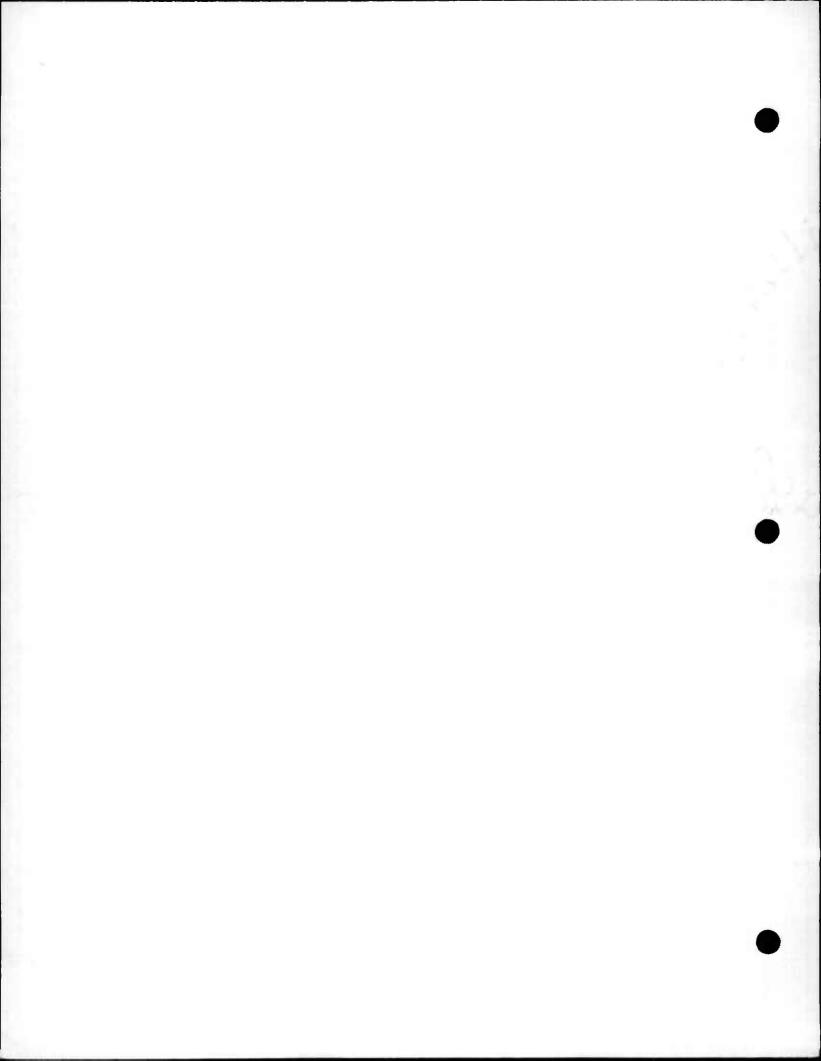


BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL, DIRECTIOR: After this certificate has been signed by the attending physician and competed.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

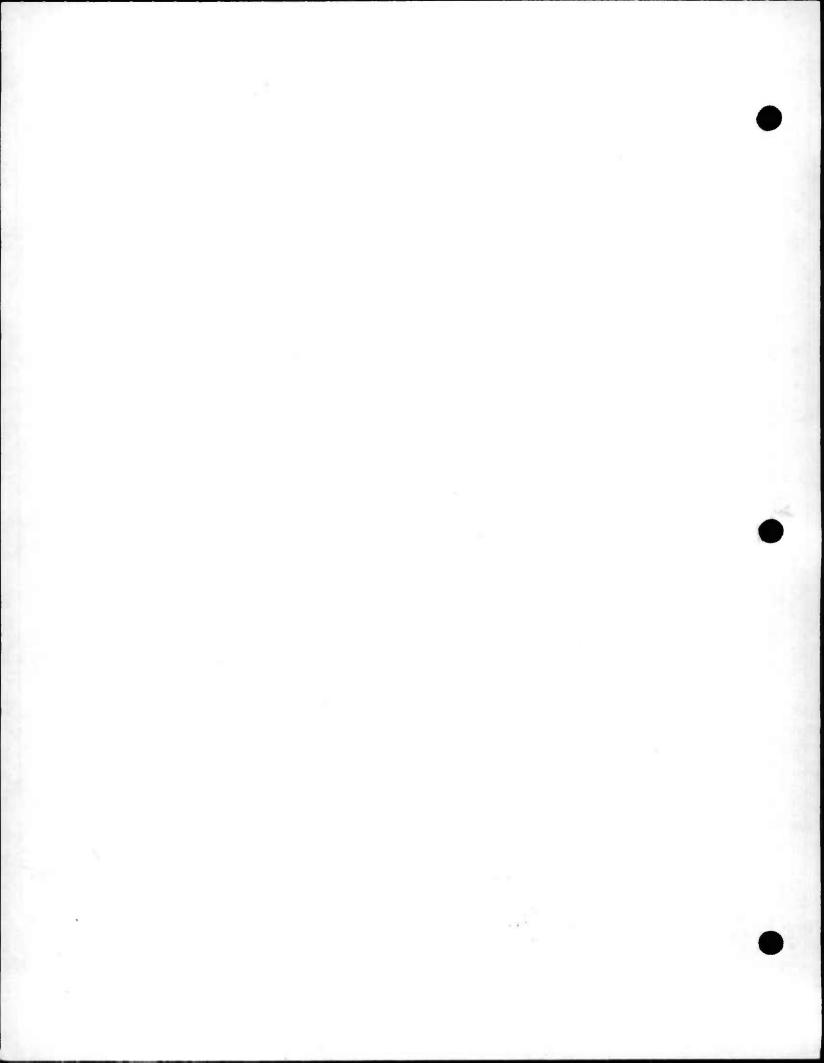
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN'	TAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF HEALT	H AND ME	NTAL HYGIENI REG. NO.	E	
		1. DECEOENT'S HAME (First, Middle, Last)				2.	DATE OF OEATH MONTH DA	W WEAR	3. TIME OF DEATH
			DOSIA	WEBB		A	pril 15,	1995	9:46 P M
Di.	1	234-44-7013	1 🗆 M 2 💢 F	82 YRS. MG	NTHS DAYS HOURS	MIN. M	DATE OF BIRTH (Month, Day, You), 1	.913 8. BIR	THPLACE (State or Foreign ntry) Ohio
, 2, 3 sho	TOR	90. FACILITY HAME (If not institution, give a Memorial Ho RESIDENCE OF DECEDENT	ospital		city, town or Loca Cumberland			sc. county of Allega	ny ny
f. rages	DIRECTOR	10a. STATE 10b. COUHTY	npshire	_	own or Location				10d. IHSIOE CITY LIMITS? 1 YES 2 NO
artisti perm	FUNERAL	100. STREET AND HUMBER 665 Fourth	Street		101. ZIP CO 2675	7		10g. CITIZEH OF	WHAT COUHTRY?
as the bunal-transm permit. Pages 1, 2, 3 shound	ВУ	11. MARITAL STATUS 1 Never Married 2 📉 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IH FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X HO	13. WAS OECENOEHT If yes, specify Cui 1 YES 2 X Ho	ban, Mexican, P	ORIGIN? (Specify Yes uerto Rican, atc.)	Ble	CE — American Indian, lok, White, etc.
io na	COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATIOH completed) College (1-4 or 5+)	16e. OECEOENT'S US (Give kind of work life. Do NOT use no Homemak	done during most of won tired.)	king	16b. KIHO OF BUS	INESS/IHOUSTRY	
at once.		17. FATHER'S HAME (First, Middle, Last) Clarence E.	Wood			THER'S NAME (First, Middle, Meiden : Bosley	Surname)	
notffled	TO BE	19e. INFORMANT'S NAME (Type/Print) Mary Ann Lil	ler	19b. MAILING AC	oness (Street and Number St., Ro	oer or Rural Route	Number, City or Town WV 2675		
must be		20e_METHOO OF OISPOSITION 1	oval from State 20b.	PLACE AHOOATE OF C	place) Cemetei	ry Marc	DATE 20c. LOC	CATION - City or	Town, State
examiner		21. SIGNATURE OF FUNERAL BERVICE AC	Melle		Shaffer Romney,	Funera WV 2	1 Home, 1	Inc.	
i, cremation, or removal event, the medical		23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition rasulting in daath)	Sepsis	the death. Do not ch line.	anter the mode of d	lying, auch as	cardiac or reapir	ratory arreat,	Approximeta Interval Batween Onset and Death 24 Hours
matic	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. Gangrene o	f both Le	gs				48 Hours
Mental Hygiene prior Ijury, or other trau	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST Saddle Embolism OUE TO (OR AS A CONSEQUENCE OF): d							
and a	MEDICAL	PART II. Other algnificant condition	a contributing to deeth bu	t not resulting in t	he underlying ceuse	given in Par	24a. WAS AN / PERFORI	MEO?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
State Dept. of Health Item 23 shows an		DID TOBACCO USE CONTE				CERTAIN [1 TYES 2 NO
State	SICI	EXAMINER?	HOSPITAL:		THER:	S.,			
death with the	BY PHYSICIAN:	27. MANHER OF DEATH 1 X Hatural 8 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O		284	1. OEŞCRIBE HOW IH	JURY OCCURED	
28 Br		3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF IHJURY - building, atc. (Specifi	— A1 home, ferm, atree	t, fectory, office	281	. LOCATIOH (Street ar City or Town, State)	nd Number or Rural	Route Number,
Nin 72 hours VT: If Item	COMPLET		CIAH: To the best of my knowle						(s) and manner as stated.
be filed within 7	O BE C	29b. SIGNATURE AHO TITLE OF CERTIFIER	aft			19318		29d, DATE SIGNE	D (Month, Day, Year)
	F	30. NAME AND ADDRESS OF PERSON WHO			nt)	2,310			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
,	3	Dr. Ranjithan, 51			rland, MD	21502			
		APR 2 0 199	32. REGISTRAB'S SIGNA	or Randall					



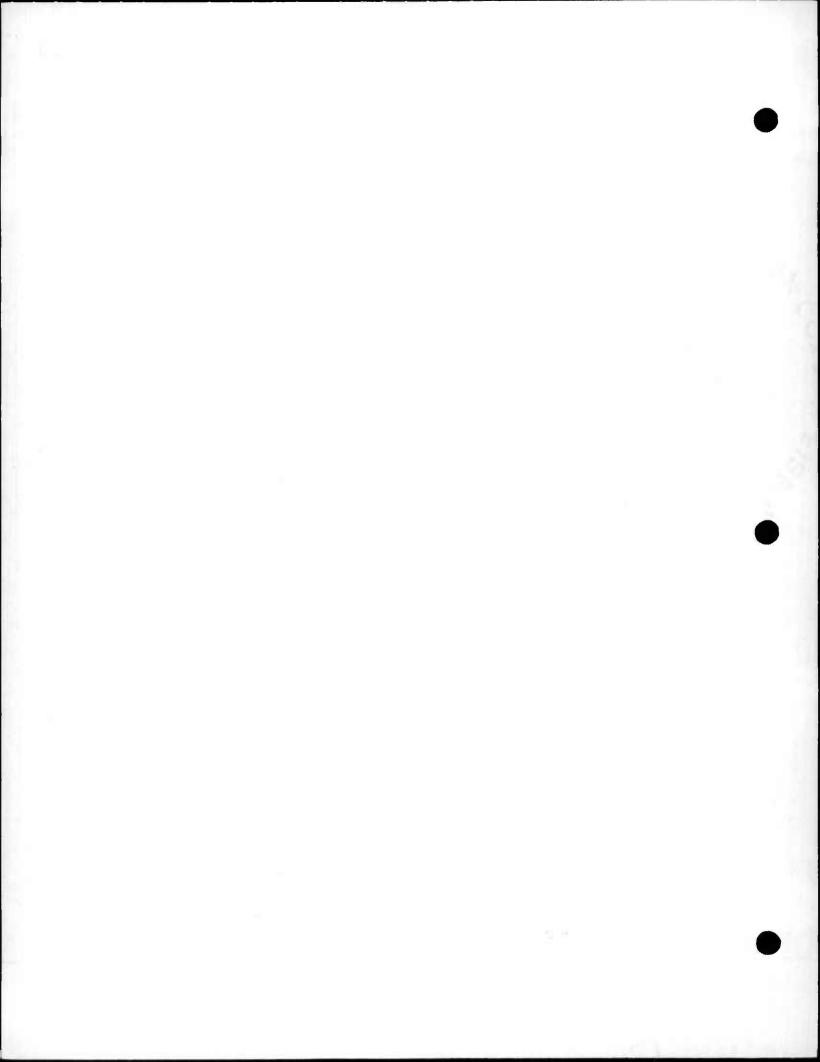
0700-0171	r attending physician.	use as the burial-trans
HILANDA	ed by the hospital	suid be detached for
DALLIMORE, MARTLAND ZIZIS-0020	age 6 may be retain	director, page 5 sho
DALI	hours after death. P	ed in by the funeral
ADS, F.O. BOA 00/00	at the death certificate be executed within 24	by the attending physician and completely fill
DISION OF ALL AL ALCOHOS, T.O. DOA 667 60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-fram
	TO THE HOSPITA	TO THE FUNERA

	1. DECEDENT'S NAME (Fir	st. Middle Last							EATH	1.3		G. NO.				
	MILDRED CROSBY WALTER								Apr 1		1995	YEAR	3. TIME	OF OEATH		
		A SOCIAL OSCIPITY MUMOST						UNDER 24 HRS.	7. 0	ATE OF BIE	RTN	1			tete or Foreign	
	212-20-1310)	1 🗆 M 2 💢 F	80)	YRS. MO	NTHS DA	VS HO	OURS MIN.	Se	(Month, Day, Year) Country)		WV			
ECTOR	9e. FACILITY NAME (If not	institution, give	street and number)						OCATION OF			<u> </u>	9c. COU	NTY OF E	DEATH	
	FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY															
EC	10e. STATE	10b. COUNT	TY 10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY					
E C	MD Exadorials Designed I									TS?						
FUNERAL									NTRY?							
NE	200 E. 161	th Stre							701				USZ	A		
- 1	1 Never Merried 2	Merried	12. WAS DECEDEN	YES	2 X N	MED IO	If yes	, specify	ENT OF HISP Cuban, Mexi	can, Pu	RIGIN? (Spe erio Ricen,	cify Yee o atc.)	or No-	14. RAC Blec	E — Ameri k, White, e	can Indien, tc.
ВУ	3 ₩idowed 4 □ Div	IF YES, GIVE Y	IF YES, GIVE WAR OR DATES				YES 2	X NO Spec	offy:				Spec	white		
윤	15. DE (Specify of	CATION completed)		(G)	CEDENT'S USL	done during	PATION	working		16b. KIND	OF BUSI	NESS/IND		WILLCO	<u>-</u>	
LET		Elementary/Secondary (0-12) College (1-4 or 5+)														
COMPL	12 17. FATNER'S NAME (First,	Miciria Last	-		ho	memake	er	1				n ho				
υ U	William		n					18	MOTNER'S N		irst, middie. Jarre		iumame)			
00	190. INFORMANT'S NAME				19t	. MAILING ADI	DRESS (Str	eet end N					State, Zip	Code)		
2	George E.	196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 12124 Marigold Avenue: Cumberland, MD 21502														
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State															
	Smithsburg Crematorium 04/18 Smithsburg, MD															
- 1	22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home															
	Cumberland, MD 21502									ner	al Ho	me				
	7000	71	1 cay	M	4		Cum	ber.	land,	MD	21502	2				
	23. PARI I. Enter the shock, or	diseases, or heert fellure.	complications the	t caused	the de	ath. Do not a	Cum	ber.	land,	MD	21502	2	atory err	rest,		proximata
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	snock, or i	neert reliure.	Acut	e My	OC2	rdial	Cum anter tha	mode o	Land, of dying, su	MD	21502	2	atory err	rest,	One	erval Batwe set and Da
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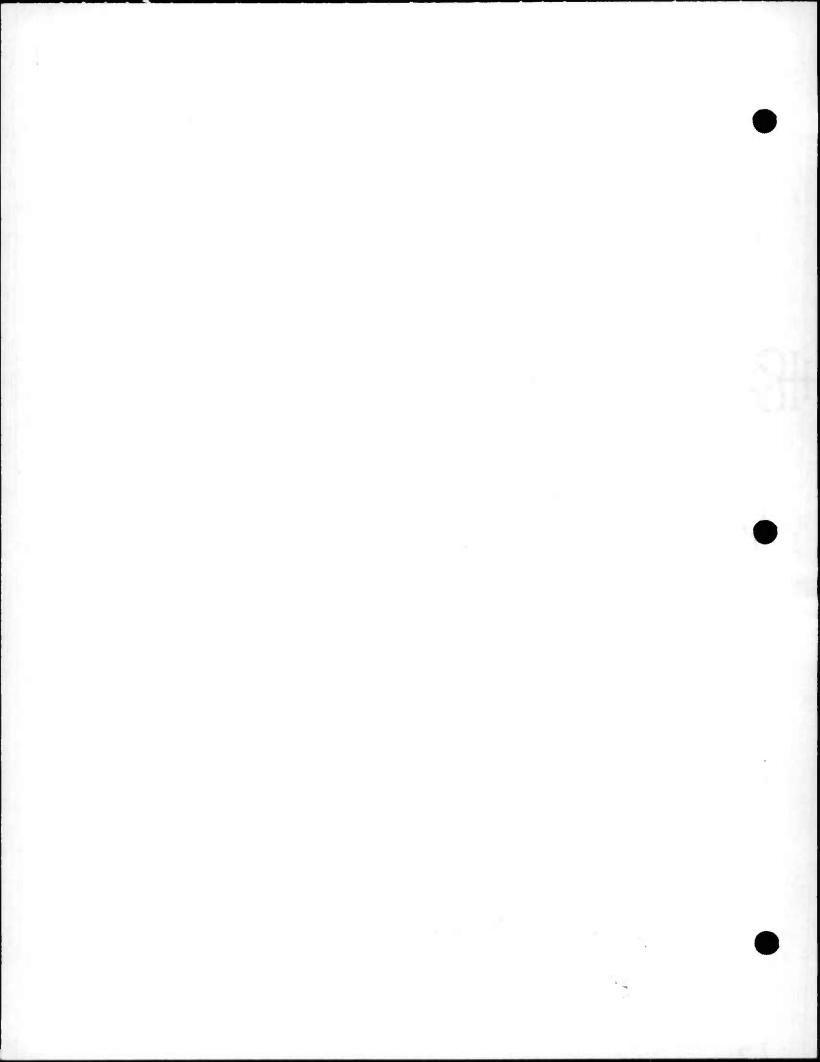
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0	hat the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician.	d by the attending physician and completely filed in by the furnish decision, page 5 should be detached for use as the burial-transit and Mental Hydies proving the property of personal
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Z	at th	and by

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND DEATH	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)				*	2. DATE	OF DEATH		3.	TIME OF DEATH
		lilson				Apr	il 22,		EAR 1	2:00
	4. SOCIAL SECURITY NUMBER 235-36-4863 A	1 □ M 2 X F 9	(In yrs. lest birthday) O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb	OF BIRTH Day, Year) 19,	1905	BIRTHPLA Country) Ohi	CE (State or Foreign
ECTOR	9a. FACILITY NAME (if not institution, give s 18 Georgetown R				or Location of C	DEATH		9c. COUNTY	of DEAT	
E E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c, CITY	, TOWN OR LOC	ATION				10/	d. INSIDE CITY
DIR	Maryland Fre	derick	Wa	alkersv:	i 110					LIMITS?
AL	10e. STREET AND NUMBER		1 111		Of. ZIP CODE			10g. CITIZEI		COUNTRY?
FUNERAL	18 Georgetown Ro	ad			21793			Unite	d St	ates
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 XNO	If yea, s	CENDENT OF HISPA pecify Cuban, Maxie S 2 NO Spec	an, Puarto i	? (Specify Yea Rican, etc.)	or No.— 14		American Indian, hita, atc.
8	15, DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b.	KIND OF BUS	SINESS/INDUS	TRY	White
1 1	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of w life. Do NOT us	ork done during n e retired.)	nost of working			32007.11.1500		
COMPLI	8		Wait	ress]_]	Food S	ervice		
COM	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First, I	fiddle, Maiden	Sumame)		
BE	Charles B. Write	sel			Mary					
TO BE	19a. INFORMANT'S NAME (Type/Print)	1	1		and Number or Rura				,	
	Frances J. Star				m_Road_					
	1 Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from State 20b	PLACE AND DATE Of etery, crematory or oti	F DISPOSITION (A	leme of	DATI	20c. LO	CATION — City	or Town,	he, Ohio
	21. SIGNATURE OF FUNERAL SERVICE LIK	CENSES (7)	Loral Hil	LS Memo	ory Garde	n 4/2	26/95	Chill	icot	he, Ohio
		(1) ~ _		1621	Oncount	.orm 1	aurre	r Fune	ral	Homes, P.
\vdash	Janny		uge		Opossumt					MD 2170
	23. PART I. Enfor the diseases, or shock, or heart/failure. IMMEDIATE CAUSE (Final	complications that caused List only one cause on e	the death. Do n non line.	ot enter the m	ode of dying, au	ch as card	fac or respi	ratory arrest		Approximate interval Between Onest and Desti
	disease or condition resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	ANCER	NECK	_				4 , , , ,
NOI	Sequentially list conditions,	b DUE TO (OR AS A	CONSEQUENCE OF	1:						
ICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	с							į	
ERTIFI	that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
L C	PART II. Other significant condition	s contributing to death b	ut not resulting in	the underlying	ng cause given in	Part I.	24a. WAS AN	AUTOPSY	24b. WEI	RE AUTOPSY FINDINGS
ICAL		OPD					PERFOR		AVA	ILABLE PRIOR TO MPLETION OF CAUSE
MEDIC		1472				_	1 TYES 2	Suco		DEATH? YES 2 NO
AN: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTA	N Ø	4		'-	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one		- 4				
YSI	1 TES 2 NO	1 Inpatient 2 ER/Outp	atlent 3 🗆 DOA	OTHER: 4 Nursing Hor	me 5 Residence	8 🗆 Other	(Specify)			
РНУ	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 28c. IN	JURY AT ORK?	28d. DE\$	CRIBE HOW IN	NJURY OCCUR	ED	
B	1 Netural 5 Pending 2 Accident Investigation				YES 2 NO					
8	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, st	reet, factory, offi	ca .	28t, LOCA	ATION (Street a or Town, State)	and Number or I	Rural Route	Number,
MPLET	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowl	edge, death occurre	d at the time, dat	a and place, and du	to the cau	se(a) and men	ner as stated.		
O BE COM	0700) 2 MEDICAL EXAMINE	R: On the beals of expenination	and/or investigation	, in my opinion,	death occured at the	time, data	and place, and	d due to the co	ause(a) and	d manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFICATION				29c. LICENSE NU			29d. DATE St		
m		\mathcal{L}		•	D 32171			N	2419	
2	30. NAME AND ADDRESS OF PERSON WH					<u> </u>			-711	
	Dr. Richard Gough	n, M.D. 19 F	rederick	Road	Walkersv	ille,	Mary1	and :	21793	3
	31. DATE FILED (Month, Day, Year) APR 2 4 1995	32. REGISTRANIS SIGN	LOT Rarbell							



2, 3 should

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIFI	TMENT OF H	EALTH AND DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Las	t)				2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
1	Ruth	Isabelle		IAMS		April 2		4:10 pm M
	4. SOCIAL SECURITY NUMBER 219-20-3238	5. SEX 6. AGE	(In yrs. lest birthday) 85 YRs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb 7, 19	1.0 s. sirr	THPLACE (State or Foreign
_	9a. FACILITY NAME (If not institution, give				R LOCATION OF D	EATH	9c. COUNTY OF	DEATH
DIRECTOR	Meridian Nursin	ig Center		Frede	erick		Fred	erick
III	Maryland Fr	rederick	10c. CITY	TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	ederick			Sville		40. 01717511 05	1 TYES 2 X NO
FUNERAL	9545 Fingerboar	d Road			217	54		.S.A.
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 XNO	It yes, spi	ENDENT OF HISPAI polify Cuban, Mexica 2 X NO Specifi	NIC ORIGIN? (Specify Yea an, Puarto Rican, etc.) ly:	Bia	CE — American Indian, ck, Whita, atc. Polity: Black
	15. DECEDENT'S EC (Specify only highest gra	DUCATION de completed)	18a. DECEDENT'S 1	USUAL OCCUPATIO	DN et of working	16b. KIND OF BUS	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use	retired.)	st or working	D .		
OM	17. FATHER'S NAME (First, Middle, Last)		Waitre	SS	19 MOTHED: NA	Restau		
BE C	John	Henry	TH	OMPSON	Ora	CME (FIRST, MICOIN, MAIGHT	Surname)	SMITH
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		
	Mary Ann Thornto							yland 21701
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ra 4 Donation 8 Other (Specify)	movel from State	metery, crematory or oth	ar planel			CATION — City or	3,000
	21. SIGNATURE OF FUNERAL SERVICE	JCENSEE	penezer c	22. NAME AN	D ADDRESS OF FA	CILITY		lle,Maryland
- 5	OF Ha	W 11				II Funeral		
	23. PART I. Enter the diseases, D	complications that cause	ed the deeth. Do no	ot enter the mod	FOREST 1	Drive, Anna	apolis.	MD 21401 Approximate
	immediate cause (finsi disesse or condition resulting in death)	e. CV	A CONSEQUENCE OF					Interval Between Onset and Death
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	A CONSEQUENCE OF					
CERTIFICATION	CAUSE (Disease or Injury that Initisted events resulting in death) LAST	c. DUE TO (OR AS	A CONSEQUENCE OF	:				
	PART II. Other significent condition	ons contributing to death	but not resulting in	the underlying	ceuse given in	Part i. 24a, WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
DICA						PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDI								OF DEATH?
A.	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE (UNCERTAII	N 🖄		
Sici	EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:				
PHYSICIAN:	27. MANNER OF DEATH	1 Inputiant 2 ER/Out	28b. TIME	OF 28c. INJU	JRY AT	8 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	IRY WOL	RK? ES 2 NO			
<u>a</u>	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJUR building, etc. (Spe	Y — At home, tarm, at scriy)	reet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,
PLE	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my know	wiedge, death occurred	f at the time, date	and place, and dua	to the cause(a) and man	ner se stated.	
COMPLET		NER: On the beals of examination						(a) and manner as stated.
H	29b. SIGNATURE AND TITLE OF CERTIFI	Corpus			29c. LICENSE NUI		29d. DATE SIGNE	D (Morth, Day, Year)
2	30, NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, I	Print)	D1397	11	(1)	
	Dr. Robert L. K	aufmann, M.D.	., 300 Wes	st Ninth	Street,	Frederick	, Maryla	and 21701
l İ	31. DATE FILED (Month, Day, Year)	32. REDISTRAR'S SIGI	NATURE P				-	
	APR 2 4 199	13	- warball		_			

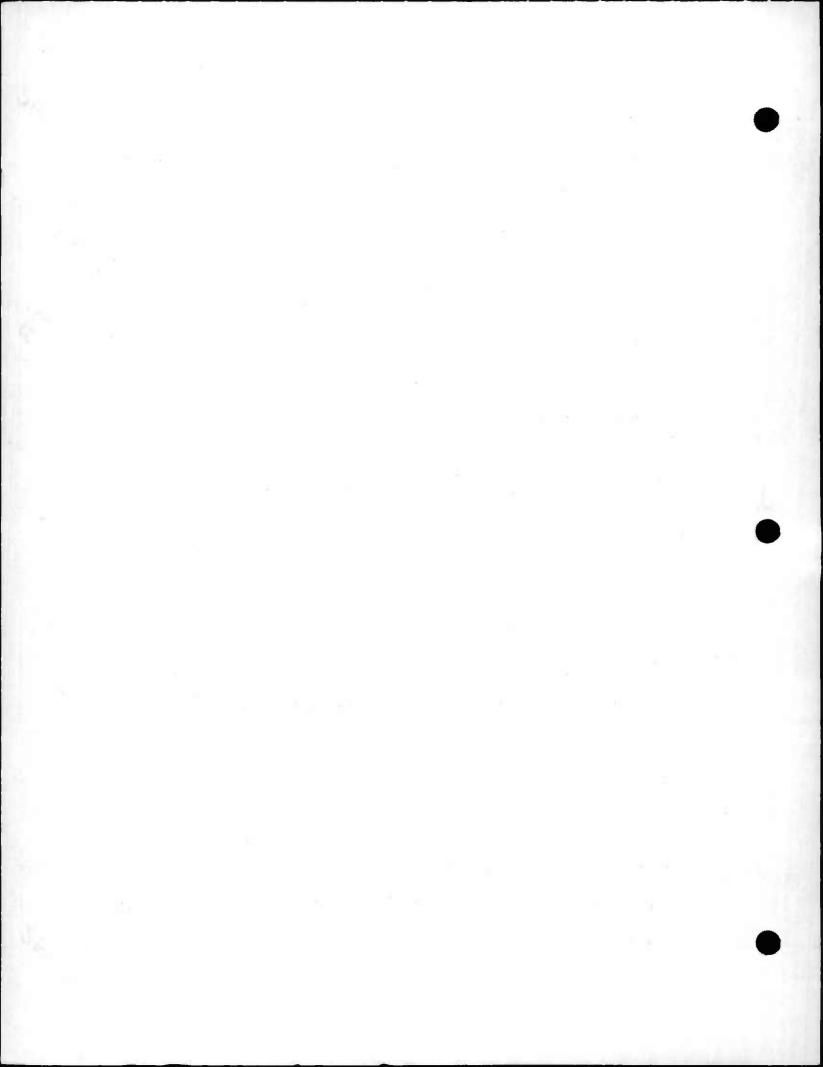


BALTIMORE, MARYLAND 21215-0020 nour after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

				SHIIF			REG. NO			
Latha Alma	st, Middle, Last)	We	ebb				April 18	1995	3. TIME OF DEATH 9:45	
4. SOCIAL SECURITY NUM	IBER	5. SEX	6 AGE (In ure Inc	et hiethelms I	IE IIMPER 1 VEA	B I I I I I I I I I I I I I I I I I I I	-			
217-30-566	What Day Herd				914 S. BIRTNPLACE (State or Foreign Country) West Virgini					
	Sa. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWH OR LOCATION OF DEATN 9c. COUNTY OF DI			
Freder: RESIDENCE OF DE 100. STATE Maryland	Frederick Memorial Hospital					Frederick				
10a. STATE	10b. COUNTY			10c. CITY	, TOWH OR LO	CATION	-		10d. INSIDE CITY	
		Frederi	ck		Fred	erick			LIMITS?	
100. STREET AND NUMBER		ces?	n 1			101. ZIP CODE	701		ZEN OF WHAT COUNTRY?	
<u> </u>	2733	Thurston	Rd.			217	/01	Unit	ed States	
10. STREET AND NUMBER THE STREET AND NUMBER	Married	12. WAS DECEOENT FORCES? 1	YES 2		II yes,	specify Cuban, Maxi	ANIC ORIGIN? (Specify Yea can, Puarto Rican, atc.)	or No-	14. RACE — American Indian, Black, White, atc.	
3 Widowed 4 □ Div	orced	IF YES, GIVE W				YES 2 NO Spec	elfy:		Specify: White	
Specify on Elementary/Secondary (10) 17. FATNER'S NAME (First, A)	CEDENT'S EDUC	ATION completed)	(G	ive kind of w	USUAL OCCUPY	ATION most of working	16b, KIND OF BU	SINESS/IND	USTRY	
Elementary/Secondary ((0-12)	College (1-4 or 5+) Ilfe	. Do NOT us	e retired.)	•				
10				Homen	naker		Own	Home		
17. FATNER'S NAME (First, A							AME (First, Middle, Maiden			
ш		ssell C		Reed			a Josephine			
O 198. INFORMANT'S NAME			19				Route Number, City or Tow			
Donald R.		r.	100.0				Frederick,			
1 Buriel 2 Cremati	on 3 🗆 Remo	val from State	cemetery, cre	metory or ot					City or Town, State	
21. SIGNATURE OF FUNER		ENSEE	I Kest	naver	1 memor	'1al AND ADORESS OF I	AOU ITM		k,Maryland	
	7	()	2	1	a. HAME	HOUNESS OF I	Stauffe	r Fun	neral Home	
23. PART i Sylver the control of the	mal	Tele	RAM		1621	Opossum	town Pike/F	reder	ick, Md. 2170	
Sequentially list condition resulting in death) Sequentially list condition from cause. Enter UNDERLY CAUSE (Disease or loj that initiated eventa resulting in death) LAS	riNG ury		REBRAL OR AS A CONSE			ij sky			2 day	
PART II. Other aignific	FRA	ICTURE					Pert I. 24e. WAS AN PERFOR	MEO?	24b. WERE AUTOPSY FINDI AWAILABILE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO	
₹ 25. WAS CASE REFERRED	TO MEDICAL	HOODITAL				PLACE OF DEATH	theck anly one)			
O EXAMINER?	H	YES 2 NO 1 NO NOTHER: 1 Vinpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify)								
EXAMINER?		1 Inpatient 2	ER/Outpatlant 3	□ DOA		lome 5 Rasidence	8 Other (Specify)			
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	Bending	1 inpatient 2 = 28a. DATE OF (Month, De	INJURY	28b. TIME	4 Nursing N	INJURY AT WORK?	28d. DESCRIBE NOW I	NJURY OCC	CURED	
	Pending Investigation	28a. DATE OF (Month, De	INJURY IX Year)	28b. TIME 1NJ	A Nursing N E OF 28c. URY M 1	INJURY AT WORK? YES 2 X NO	FALL			
2 Accident 3 Suicide 6		28a. DATE OF (Month, De 28a. PLACE OF building,	INJURY 19, Year) 95 INJURY — At ho	28b. TIME 1NJ	A Nursing N E OF 28c. URY M 1	INJURY AT WORK? YES 2 X NO	28d. DESCRIBE NOW I FA LL 281. LOCATION (Street City or Yown, State)	and Number o	or Rural Route Number,	
2 Accident 3 Suicide 6	Investigation Could not be	28a. DATE OF (Month, De 28a. PLACE OF building,	INJURY IN Year) 9 5 INJURY — At ho	28b. TIME 1NJ	A Nursing N E OF 28c. URY M 1	INJURY AT WORK? YES 2 X NO	28d. DESCRIBE NOW I FA LL 281. LOCATION (Street City or Yown, State)	and Number o		
2 Accident 3 Suicide 6	Investigation Could not be detarmined	28a. DATE OF (Mohin, De 28a. PLACE OF building.)	INJURY IN Year) 95 INJURY — At ho etc. (Specify) NOME	28b. TIME INJI 3 - 00 ma, larm, s	4 Nursing N E OF 28c. URY M 1 [Rreel, lectory, o	INJURY AT WORK? VES 2 NO Hice	28d. DESCRIBE NOW I FALL 28I. LOCATION (Street City or Town, State) 2733 THUC 18 to the cause(s) and man	and Number of	or Aural Acute Number. PLEDECIENT LD 21-	
2 Accident 3 Sulcide 4 Nomicide 29e. CERTIFIER 1 CER (Check only one) 2 Met	Could not be determined TIFYING PNYSIC DICAL EXAMINER E OF CERTIFIER	1 X Inpetient 2 28e. DATE OF Month, De 28e. PLACE OF building,	INJURY NY Year) FINJURY — At ho etc. (Specify) O IN & my knowledge, de amination and/or	28b. TiMi 1NJI 3°-00 ma, larm, s	4 Nursing N E OF 28c. URY P M 1 [Rreel, lectory, o	INJURY AT WORK? YES 2 NO Hica Inta and place, and due, death occured at the second	28d. DESCRIBE NOW I FA L 28I. LOCATION (Street City or Town, State) 2733 THUL is to the cause(s) and mare time, data and place, an	and Number of	or Rural Route Number, PO. FLEDECIE ad. cause(a) and manner as state SIGNED (Month, Day, Year)	
2 Accident 3 Sulcide 4 Nomicide 29e. CERTIFIER (Check only one) 2 MET	Investigation Could not be determined ITTIFYING PNYSIC DICAL EXAMINER E OF CERTIFIER OF PERSON WHO	28a. PLACE OF building.	INJURY NY Year) FINJURY — At ho etc. (Specify) O IN & my knowledge, de amination and/or	28b. TiMi 1NJI 3°-00 ma, larm, s	4 Nursing N E OF 28c. URY P M 1 [Rreel, lectory, o	INJURY AT WORK? YES 2 NO Hica Inta and place, and due, death occured at the second	28d. DESCRIBE NOW I FA L 28I. LOCATION (Street City or Town, State) 2733 THUL is to the cause(s) and mare time, data and place, an	and Number of	or Rural Route Number, PO. FLEDECE A PO. Lang 217 ed. ed. e cause(a) and manner as state	

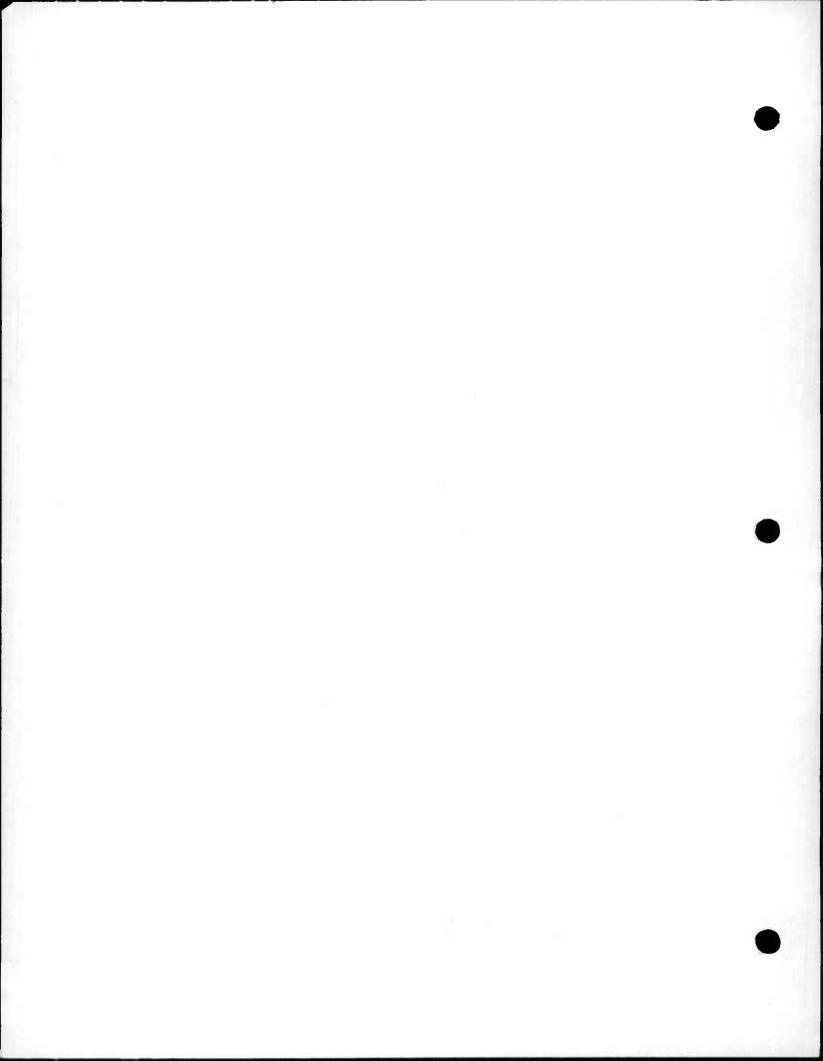


OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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or at	or use		
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the h	deta		
ed by	or blue		
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certific	d Builp	lygiene	
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AN	tificate	e Stat	14.
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OR A	DIREC	hours	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

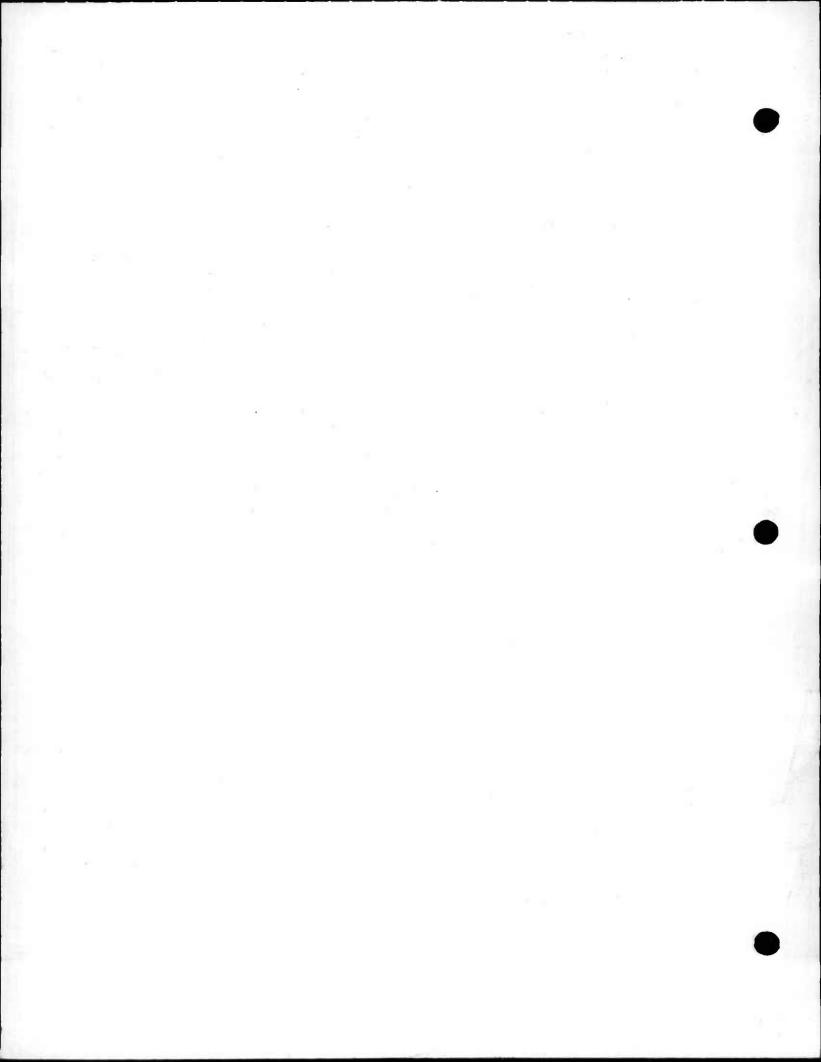
		1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND / DEPAI CERTIF	RTMENT OF H	REALTH AND I	MENTAL HYGIENE REG. NO.					
2		1. DECEDENT'S NAME (First, Middle, Last LAUREL () Genevieve		YEARGAIN		2. DATE OF DEATH MONTH DAY APRIL 24,	1995	3. TIME OF DEATH 02:00 M			
0		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign			
P		215-43-0366	1 🗆 M 2 🔀 F	YRS.	6 DAYS	HOURS MIN.	10-24-199		MD			
3 should	Œ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF DE		9c. COUNTY DF	DEATH			
2,	012	THE JOHNS HOPE	CINS HOSPITA	AL	BALT	IMORE CI	ГҮ					
2006	DIRECTOR	10a. STATE 10b. COUN		10c. CI	TY, TOWN OR LOCAT	TION	-		10d. INSIDE CITY LIMITS?			
mit.		MD	Harford			bingdon		1 🗌 YES				
be detached for use as the burial-transit permit. Pages 1, all once.	FUNERAL	117-G Wald	on Road		101	21009		10g. CITIZEN OF WHAT COUNTRY?				
al-tran	UNE	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13. WAS DEC		IIC DRIGIN? (Specify Yes o		CE — American Indian,			
bur	BY F	1 Never Married 2 Married	FORCES? 1 T		Il yes, sp	ack, White, atc.						
as the		3 Widowed 4 Divorced							White			
r use	ETE	15. DECEDENT'S ED (Specify only highest grad	de completed)	18a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mo							
of ber	PL	Elementary/Secondary (0-12)	College (1-4 or 5 +)	14,000	None							
detach once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden Su	ımame)				
d be	BE		uglas Year		Mary Pamela Topper							
5 should notified	2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town,					
be m		M/M James D. Y	eargain				Abingdon,		009			
funeral director, page 5 should xaminer must be notified		1 M Burial 2 Cremation 3 Rei	moval Irom State	20b.PLACE AND DATE cametery, cremetory or of Mit. Erin	OF DISPOSITION (Na other place)	ame of		ATION — City or	100			
al dire		21. SIGNATURE OF FUNERAL SERVICE 1	CILITY		Grace, MD							
		1.000-	$\times \cup \overline{\ }$	**	Mitch	nell-Smith	n Funeral H	lome, I	P.A.			
d in by the or removal. medical e	- 1	23. PART I. Enter the disesses, pr	complications that ca	used the death. Do	not antar the mo	e de Gra	ace, MD 2	21078-3				
		shock, or haart fellura IMMEDIATE CAUSE (Final	. List Dnly Dne ceuse t	on aech line.	not arrest the me	as or ajing, suci	r as certise or respira	ibiy errest,	Approximats Interval Between			
ely fill ration,		disease or condition resulting in death)	_	Seperis					Onset and Death			
completely ial, cremat event, t		readiting in death)	DUE TO (OR	AS A CONSEQUENCE O	D: / D	<i>i</i> -	1		7 - ((04)			
anding physician and completely fille I Hygiene prior to burial, cremation, or other traumatic event, the	N	Sequentially list conditions.	b	Liver	falle	no (Ch	olestatic,	aundi	u 3 moz			
cian ior to	ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): TOTAL Parents or Due TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
phys ane pr her t	FIC	CAUSE (Disease or Injury) that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
the attending physician Mental Hygiene prior t njury, or other traus	CERTIFICATION	resulting in death) LAST d. Magacysfre Microcolen Hypopenistalise Syndring 6 y										
he att Menta Jury,	- 1	PART II. Other significant condition	T T									
y and	CAL	Chronic Ane					PERFORM	ED?	No. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION OF CAUSE			
signe Health	MED					,	1 D/ES 2	ND	DF DEATH?			
as been Dept. of 23 sho		DID TOBACCO USE CON	TRIBUTE TO CAUS	E OF DEATH YI	ES INO X	UNCERTAIN	10		1 TES 2 NO			
DIRECTOR: After this certificate has been signed hours after death with the State Dept, of Health Item 28 is marked, or Item 23 shows an	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE DF DEA								
artifica he Stu	YSI	1 TYES ZY NO	1 - Inpetient 2 - ER/			e 5 🗆 Residence	8 Other (Specify)					
this c	РНҮ	27. MANNER OF DEATH 1 Pending	28a. DATE DF INJU (Month, Day, Ye	ear) (N.	JURY WO	RK?	28d. DESCRIBE HOW INJ	URY OCCURED				
t: After this cr r death with is marked,	BY	2 Accident Investigation	28a PLACE OF IN	JURY — Al home, Jarm,	TEM 1 1	X	10,14					
after 28 is	ED	4 Homicide 8 Could not be	building, etc.	(Specify)	street, factory, orner		City or Town, State)	Number of Hural	f Route Number,			
DIREC hours item	LET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my i		ad at the time, date	and place and disc						
₹2 =	COMPL		IER: On the beats of examin						(a) and manner as stated.			
TO THE FUNERAL be filed within 72 I	E C	296. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUM	1010-1		ED (Month, Day, Year)			
DE SIE	00	James J. Feh	r/picu!	Physicia	\sim	Manula	nd lies	N 4/24	19-			
	5	30. NAME AND ADDRESS OF PERSON W	HD COMPLETED CAUSE DE	F DEATH (ITEM 27) (Type	Print)			, , ,				
		(pm	es	ehrm-)							
		APR 26 1995	37 BEGISTRAR'S	SIGNATURE								

12.00

RECTOR	Mo11 4. SOCIAL SECURITY NUMBER 214-10-4316	ie E	_				2. DATE OF DEAT						
ш		~ ~	lzora		YOUNG	;	April 2	1, 199	5 YEAR 12:05 pm	М			
ш		5. SEX 1 M 2 X F	6. AGE (In yrs. las		IF UNDER 1 YEA		7. DATE OF BIRT	н	8. BIRTHPLACE (State or Foreign Country) Washington DC	;			
ш	90. FACILITY NAME (If not institution, give so Northampton Manor RESIDENCE OF DECEDENT		Center			n on Location of derick	DEATH		nty of DEATH rederick				
DE R	10a. STATE 10b. COUNTY	erick			y, town on Lo				10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
FUNERAL	100. STREET AND NUMBER 701 Wyngate Drive					101. ZIP CODE 21701		10g. CIT	U.S.A.				
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W	YES 2 XI		I1 yes	DECENDENT OF HISI apacify Cuban, Max (ES 2 NO Spe	PANIC ORIGIN? (Specializari, Puerto Rican, atología; et locity:	y Yea or No	14. RACE — American Indian, Black, Whita, etc. Specify: White				
LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(G life	ive kind of v Do NOT us	USUAL OCCUP work done during te retired.) Operat	most of working		tauran					
COMPL	17. FATHER'S NAME (First, Middle, Last)				орегас	18. MOTHER'S	NAME (First, Middle, Mi						
TO BE	William 19a. INFORMANT'S NAME (Type/Print)		WADF	b. MAILING	ADDRESS (Stre	Grac	al Route Number, City o	r Town, State, Zip	WHIPP O Code)				
2	Mrs. Ruth M. Gilb		20b. PLACE	AND DATE O	OF DISPOSITION	(Name of	DATE 20	LOCATION	aryland 21702 City or Town, State	_			
iner must	1X Buriel 2 Cremation 3 Removal from State 200. LOCATION - City or Town 200. LOCAT												
ai examin	22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 2170 23. PART). Enter the diseases, pr complications that caused the death. Do not enter the mode of dying, such sa cardiac or respiratory errest, Approximate												
event, the medical	shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ist only one ceu	se Dn each lina	ien	uey's	Acses	*	espiratory an	Approximate interval Between Onset and De				
CATION	Sequentially list conditions, if amy, leading to immediata ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events		(OR AS A CONSEC										
CERTIFI	resulting in death) LAST				,								
EDICAL CE	PART II. Other significant conditions	contributing to	daath but not r	asulting i	n tha undarly	ring cause given	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?				
2 2	DID TOBACCO USE CONTR	IBUTE TO CA					JIN 🗆		1 TES 2 NO				
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			H (Check only o								
BY PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, Da	INJURY	28b. TIMI	E OF 28c. URY	INJURY AT WORK?	e 8 Cher (Specify, 28d. DESCRIBE H		CURED				
TED TED	2 Accident Investigation 3 Suicide s Could not be datarmined 28a. PLACE OF INJURY — At home, farm, street, sectory, office City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, sectory, office City or Town, State)												
필	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINES	IAN: To the best of ax	my knowledge, de amination and/or i	ath occurre	d at the time, d	eta and plece, and d	ue to the cause(a) and he time, date and plac	manner as atal	ted. ne cause(a) and manner as stated				
8 8	296. SIGNATURE AND TITLE OF CENTIFIER	Lan	ان	DV	1.	29c, LICENSE N		29d. DAT	E SIGNED (Month, Day, Year)				
티입	30. NAME AND ADDRESS OF PERSON WHO Philip J. Shapiro	, M.D.,	814 Tol	1hous	se Aver			ryland	21701				
		32. REGISTRAF											



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTA	L HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF OEATH		3.	TIME OF DEATH		
		HENRY		MERMAN			Apr		6 199	5 9	:00 a.		
Pin		4. SOCIAL SECURITY NUMBER 216-07-9584 9e. FACILITY NAME (If not institution, give	1₹XM 2 □ F 92	YRS.	F UNDER 1 YEAR SONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Aug.	of BIRTH 1, Day, Year) 23 1	902 P	enns	ACE (State or Foreign ylvania		
1, 2, 3 should	TOR	Dorchester Ge				oridge	EATH		Dorc Dorc				
permit. Pages 1	DIRECTOR	10e. STATE 10b. COUNT	rchester		TOWN OR LOCAT						d. INSIDE CITY LIMITS? YES 2 X NO		
- FS	FUNERAL	6 Algonqui	n Rd.		101	ZIP CODE	613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
21215-0020 Il or attending physician. for use as the burial-transit	Β¥	11. MARITAL STATUS 1 Never Merried 2XX Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	13. WAS DEC	NIC ORIGIN en, Puerto I fy:	1? (Specify Ye Ricen, stc.)	s or No- 14		American Indian, Thite, etc. White			
215 attend	G	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S U	SUAL OCCUPATION No.	ON st of working	KIND OF BU	SINESS/INDUS	TRY				
O g g	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	intant	or working		automo	obile	deal	ership		
the hose detach	8	17. FATHER'S NAME (First, Middle, Last)	17 7	16. MOTHER'S NA	, ,								
TARYL rained by t should be tiffied at	BE	William 190. INFORMANT'S NAME (Type/Print)	K. Zimmerm					ta	•	nown)		
. 9 9 6	2	Mrs. Bernice Zimm	erman										
e 6 m	į	20e. METHOD OF DISPOSITION 1 X) Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Completely or other place) DATE 20c. LOCATION — City or Town Cambridge Mar											
death. funer		21. SIGNATURE OF FUNERAL/ SERVICE L	to & Thomas	Thomas Funeral Home 700 Locust St. Cambr							dge MD 21613		
d within 24 hours after ompletely filled in by the cremation, or removal event, the medical		23. PART I. Enter the disease, pr shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	. Acute Ant	ech line.	ll Myoca				Iratory srres	ł,	Approximate interval Between Onset end Daeti 3 days		
B 2 2 2	- 1		Arteriosc										
retan clan	CATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):									
th certific ending pl Hygiene	CERTIFICATION	CAUSE (Disesse or injury that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):									
uires that the signed by the Health and M was any Inju	MEDICAL,C	Arteriosclerot fibrillation	ns contributing to deeth be ic Cardiovasc	ut not resulting in ular dise	the underlying ease wit	ceuse given in th Atria	Pert i.	24a. WAS AN PERFOR 1 YES 2	RMED?	CO OF	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
> 0 -		DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO 🗵	UNCERTAI	ND				_ 1.23 2 _ 110		
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO	HOSPITAL:		OTHER:	s 5 🗆 Reeldence	8 🗆 Other	r (Specify)					
HYSICI His cert with the	돑	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c INJI	JRY AT			NJURY OCCUP	RED			
DING PHYS After this of death with	<u>B</u>	13_XNatural 5 Pending 2 Accident Investigation				ES 2 NO							
TOR: A after de 28 is		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	At home, ferm, stri ify)	set, fectory, office		281. LOC. City	ATION (Street of or Town, Stete)	and Number or	Rural Route	Number,		
로 크 로 트	COMPLET	29e. CERTIFIER (Check only one) 1 XXCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated.											
B FUN		29b. SIGNATURE AND TITLE OF CERTIFIE			I	29c. LICENSE NUI					onth, Day, Year)		
TO THE HOSPIT TO THE FUNERA be filed within 7	O BE	5	Comman			D 14349					26,1995		
	10	30. NAME AND ADDRESS OF PERSON WIRE Eyup Tanman, M	.D. 15 Fran	klin St.,	Cambri	dge MD	21613						
15		31. DATE FILED (Month, Day, Year) APR 9. 7 1995	HEGISTRAR'S SIGNA	hardall									



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CERTIFICATION

PHYSICIAN: MEDICAL

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disease Dr condition resulting in deeth)

Sequentielly list conditions, if any, leading to immediate

cause. Enter UNDERLYING CAUSE (Disease or injury

296. SIGNATURE AND FIFTE OF CENTIFIES

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	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAN	ND / I	DEPAR RTIF	TMENT	OF H	EALTH DEA	AND I	MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) Nellie E. Ze	eigler								2. DATE OF DEATH MONTH April 19	, 1	995	3. TIME OF DEA	
	4. SOCIAL SECURITY NUMBER 212-38-7613	5. SEX 1 M 2 K	6. AGE (In y	yrs. lest	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov 23, 1		6. BIRTH Countr	IPLACE (State or i	Foreign
DIRECTOR	96. FACILITY NAME (If not institution, give s Meridian Healt Aspent RESIDENCE OF DECEDENT	treet and number) ch Care lood	Cent	er	at				on of DE	ATH	9c. COU	INTY OF D		
		tgomer	Y			y, town o aith			g				10d. INSIDE CIT LIMITS?	
FUNERAL	8 West Deer I	ark Dr	ive -	- A	pt	103	10f	2 ()	§ 877		10g. CIT		S · A ·	
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES :	2. NO	ED)	1	yes, spe	ENDENT (ecity Cube 2 XNO	n, Maxica	IIC ORIGIN? (Specify Years, Puerto Ricen, etc.)	or No—	14. RACE Black Specia	- American Inc. White, atc.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12) 1 2			(Give	a kind of v	usual oc work done of se retired.) ide	CCUPATIO	ON st of working	ng	Montgomery County School System				
BE COI	17. FATHER'S NAME (First, Middle, Last) Charles T. Z	Zeigler.	sr.							ME (First, Middle, Meiden Le E. Dor				
5	Joyce E. Zeig]	er		19b.	MAILING 743	Sun	set.	nd Number Vi	or Rural F ew]	Jane, Fre	n, State, Zi, eder	ick,	Mary	land
	20a METHOD OF DISPOSITION Burlel 2 Cremetion 3 Remote 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		20b.PL cemeter P1e	ry, creme	atory or o	ther place) Gro	ve	Cem	etei	cy 4/22 I		SCUS		1 and
	Four L.	Will	lam			01	in 401	L. Ri	Mole dae	esworth, F Road, Da	mas	cus,		
	23. PART I. Enter the diseases, pro ehock, or heert failure. IMMEDIATE CAUSE (Finel	complications that List only one cau	t caused the	he deel h line.		ot enter		de of dy	ng, auct	h aa cerdlec Dr reepi	retory ar	reet,	Approximinterval E	nate Batween

resulting in deeth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 TYES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO W UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TES 2 TANO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 - Residence 6 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 20c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, LICENSE NUMBER

D4343

lu 2 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thaker Gaurang M.D.18111 Prince Philip Dr. Olney, Md 31. DATE FILED (Month, Day, Year)

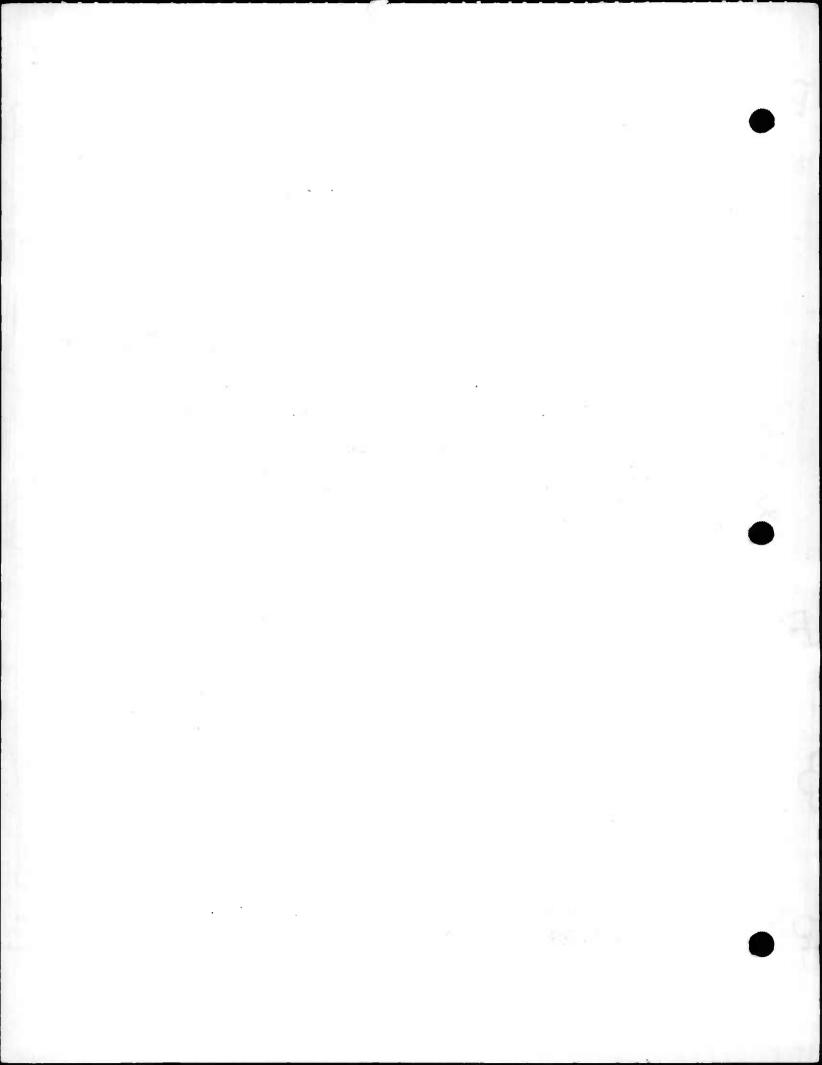
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DUE TO (OR AS A CONSEQUENCE OF)

32. REGISTRAR'S SIGNATURE 2

29d. DATE SIGNED (Month, Day, Year)

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BALTIMORE, MARYLAND 21215-0020	res that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical	igned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia
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	_	1 - STATE REGISTRAR		STATE OF I	MARYL	AND / DEPA	RTMEN FICAT	T OF H	DEAT	AND I	MENTA	L HYGIEN REG. NO	E		
		1. DECEDENT'S NAME (Flist, M BABY GIRL	-					ALL	EN		MONT		1995	YEAR	O3:20 A M
_		4. SOCIAL SECURITY NUMBER	R	S. SEX	6. AGE	(in yrs. lest birthde) YRS.	MONTHS	DAYS	IF UNDER	MIN.	7. DATE (Mon	OF BIRTH		Country)	ACE (State or Foreign
2, 3 should	OR	9a. FACILITY NAME (If not instit		PKINS HOS	PTT/	ΔΤ.			OR LOCATI		EATH	11 0,		TY OF DEA	
Pages 1.	DIRECTOR	RESIDENCE OF DECE	DENT		71 111		TY, TOWN			OII.				1	Dd. INSIDE CITY
permit.		Maryland 100. STREET AND NUMBER						101	. ZIP COD	E			10g. CITIZ		YES 2 NO
215-0020 attending physician. ise as the bunal-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 VNO	13.	If yes, sp	ENDENT Cuba ecity Cuba 2 NO	n, Maxica	n, Puarlo	N? (Specify Yea Rican, etc.)	or No—	14. RACE - Black, 1 Specify:	- American Indian, White, atc. Black
21 g d d	MPLETED	15. DECED (Specify only hi Elementary/Secondary (0-12		CATION completed) College (1-4 or S	+)	(Give kind o	ECEDENT'S USUAL OCCUPATION live kind of work done during most of working . Do NOT use retired.)							JSTRY	
ज हिंदू	BE COMPL	17. FATHER'S NAME (First, Middle) James Alley 190. INFORMANT'S NAME (Typo	n			JAN MAU II	C ADDOS	0.40	P	atri	cia	Middle, Malden	en		
. 28 0	임	Patricia A	. A11		201		East	41st	Str			timore		rylan	
BALTIMORE bours after death. Page 6 may hours after death. Page 6 may ed in by the funeral director, pa or removal. or removal. medical examiner must b		1 □ Burial 2 △ Cremation 4 □ Donation 6 □ Other (Sp 21. SIGNATURE OF FUNERAL S	pecify)		Cer I	netery, cremetory of he John	other place S Hop	kins	HOS	pita ss of FA	14/1	.0/95 E	Baltin	nore,	Maryland
BALTIN rs after death. Pag n by the funeral di removal.		The Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, Maryland 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying such as cardiac or respiratory arrest.													
within 24 within 24 operation cremation.		shock, or has IMMEDIATE CAUSE (Finel disease or condition resulting in death)	rt ranure.	. CONSEA	UITA	ach lina.	T DK								Approximats Interval Between Onset and Daath A days
A 68 on and an and r to burn	RTIFICATION	Sequentially list conditions, if sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
death cert attending ental Hygie	CERTI	that initieted avents resulting in death) LAST	<u> </u>	i											>
AL RECORDS, P.O. BO e law requires that the death certificate b has been signed by the attending physici Dept. of Health and Mental Hygiene prio 23 shows any injury, or other tra	N: MEDICAL	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 Yes 2 \(\text{NO} \) NO 1										ERE AUTOPSY FINDINGS RALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO			
- 2201	SICIAN:	25. WAS CASE REFERRED TO MEXAMINER?	MEDICAL	HOSPITAL:		26. PLACE OF DE	OTHE	R:	5 🗆 Ra	airlanca	6 🗆 Othe	er (Smanthy)			
ATTENDING PHYSICIAN: The ECTOR: After this certificate his safter death with the State D 28 is marked, or Nem	ву Рну	27. MANNER OF DEATH 1 Metural 5 Per 2 Accident	nding estigation	26a. DATE OF (Month, D	INJURY ay, Ybar)	28b. Ti		28c. INJU	JRY AT			SCRIBE HOW IP	JURY OCCU	JRED	
DR ATTENDIN DIRECTOR: Af hours after de Item 28 is 1	Œ	4 Homicide date	uld not be armined	28s. PLACE O building,	F INJURY etc. (Spec	' — At home, farm cify)	street, fac	lory, office			28f. LOC City	ATION (Street a or Town, State)	nd Number o	r Rural Roul	e Number,
¥ 25 ₹	COMPLE	one) 2 MEDICAI	L EXAMINE												nd manner as stated.
TO THE HOSP TO THE FUNE be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER Paul NP 296. LICENSE NUMBER M 1960 > 4/10/95													
			PKI	ns Ho	SPIT	AL, B	ALT	mo	DEE,	M	٥.	(MI	ARIA	A .	PANE MD)
		31. DATE FILED MONTH DO YOU	1995	32 AGGISTA	B'S SIGN	ar-hardall									

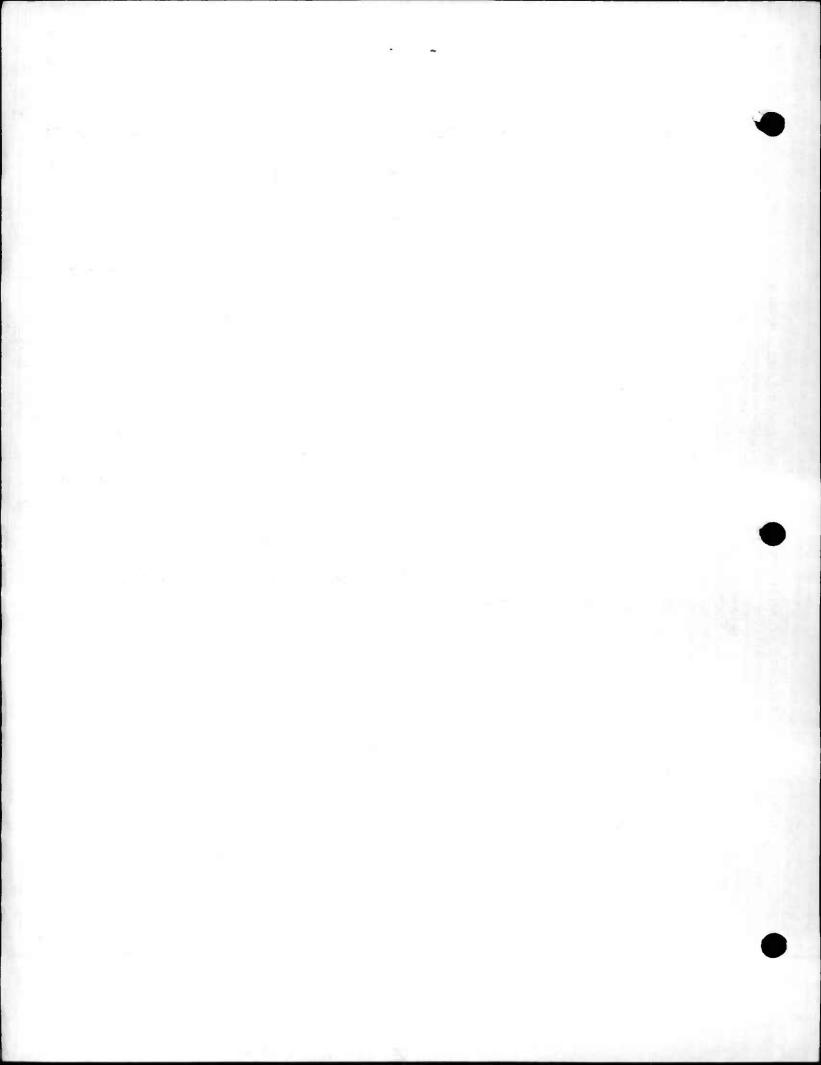
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacthed for use as the bunlat-transit permit. Places 1, 2	2	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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100	1. DECEDENT'S NAME (First, Middle, Las	Ano	dritz						2. DAT			15	3. TIME OF DEATH	
	4. SOCIAL SEGURITY NUMBER 099-16-8993	5. SEX	6. AGE (In yrs. las	YRS.	IF UNDE	DAYS	HOURS	MIN.	Jul	y 12,	192	0 Bi	PLACE (State or Foreign uffalo, N	
20	98. FACILITY NAME (# not institution, give Charles Co. No RESIDENCE OF DECEMENT		ome			aP1	ata	ION OF D	EATH			arle		
DINECTOR	10a. STATE 10b. COU	harles			wbu		TION						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	8919 Emerald	Lane			101. ZIP CODE 20664				10g. CITIZEN				U.S.A.	
5	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		YES 2 NO If yes, specify Cuban, M					ENT OF HISPANIC ORIGIN? (Specify Yes or No- 14. RACE — An Black, White					- American Indian, White, etc.	
	15. DECEOENT'S E (Specify only highest gra Elementary/Secondary (0-12)		(G	CEOENT'S live kind of Do NOT u	Work done se retired.)	during mo	ON est of world	ng	16	b. KIND OF BU	SINESS/IND	USTRY		
	12 17. FATHER'S NAME (First, Middle, Last)		" Mai	nten	anc	e S						1 Go	overnment	
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2	T. Dottie And:	ritz	8	6. MAILING 919	Eme	ral	d La	or Rumi ne	New	burg,	vn, State, Zip MD	2066	54	
	20a. METHOD OF DISPOSITION 1	emoval from State	206. PLACE	and date	OF DISPO	n C	re.	Apr	il°^	23,19	95 A	City or Tow	wn, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE AREHART—ECHOL'S FUNERAL HOME, INC.														
	David C.	Ehol	MO	0945	Ä P	REH	ART- Box	56	OLS 7 L	FUNE aPlat	RAL a,MD	HOMI 2 (
	23. PART I. Enter the diseases, o shock, or heart feliur IMMEDIATE CAUSE (Finel disease or condition resulting in desth)	Echolor complications the e. List only one cen	MOO at caused the de use on each line	0945 path. Do 1	A P	REH.	Box de of dy	ing, suc	OLS 7 L	FUNE aPlat	RAL a,MD	HOMI 2 (E, INC.	
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	23. PART I. Enter the diseases, or shock, or heart feliur immediate CAUSE (Finel disease or condition resulting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST PART II. Other algnificant conditions or success of the conditions of the c	To the basis of a	MOO It caused the de use on each line (OR AS A CONSECT (OR AS A	O945 ath. Do is. QUENCE O QUENCE	Protented at the ed at the	REH O. r the mo	g cause ace of the same and place a	given in	Part I.	FUNE aPlat diac or reep 24a, WAS AN PERFO 1 YES: CATION (Street or Town, State	RAL a, MD liratory arrow AUTOPSY RMED? NO INJURY OCC and Number oner se state and due to the	24b.	Approximate Interval Betwee Onset and Des On	



BALT.MORE, MARYLAND 21215-0020

O. BOX 68760. σ. DIVISION OF VITAL RECORDS,

page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should retained by the hospital or attending physician. notified ours after death. 'age 6 may be must be funeral director, examiner completely filled in by the rial, cremation, or removal. medical the event, requires that the death certificate be executed within attending physician and con mal Hygiene prior to burial, traumatic other 0 signed by the atte injury, 23 shows any has been s Dept. of H HOSPITAL OR ATTENDING PHYSICIAN: The law item this certificate h the 9 Is marked, After the DIRECTOR: / 28 MPORTANT: if item THE HOSPITAL (
THE FUNERAL (
filed within 72 h 223

Item7 g 723 5 31 95 perF H dk FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY 1995 April 13, 7:35 am Mary G. Actis 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 7371 37 Octobe 15, 1927 1 M 2 X F 229-27-8883 67 Virginia 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg 1 TY YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 923 Clopper Road #A-4 20878 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 TYES 2 X NO ВҰ Specify: Specify: 3 🛛 Widowed 4 🗌 Divorced White ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) BE Charles Edwards Burns Ethel Louise Flora 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Jewel Glisson 923 Clopper Road #A-4 Gaithersburg, Maryland 20878 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) April 18, 20a METHOD OF DISPOSITION

1 ABurlet 2 Cremetion 3 Removal from State 20c. LOCATION - City or Town, State 1995 4 Donetion 5 Other (Specify) Woodlawn Memorial Gardens Norfolk, Virginia 22 NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin
Avenue Bethesda, Maryland 20814-3501 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00335 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. intarval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition ARDIAC ARRHY THMIA

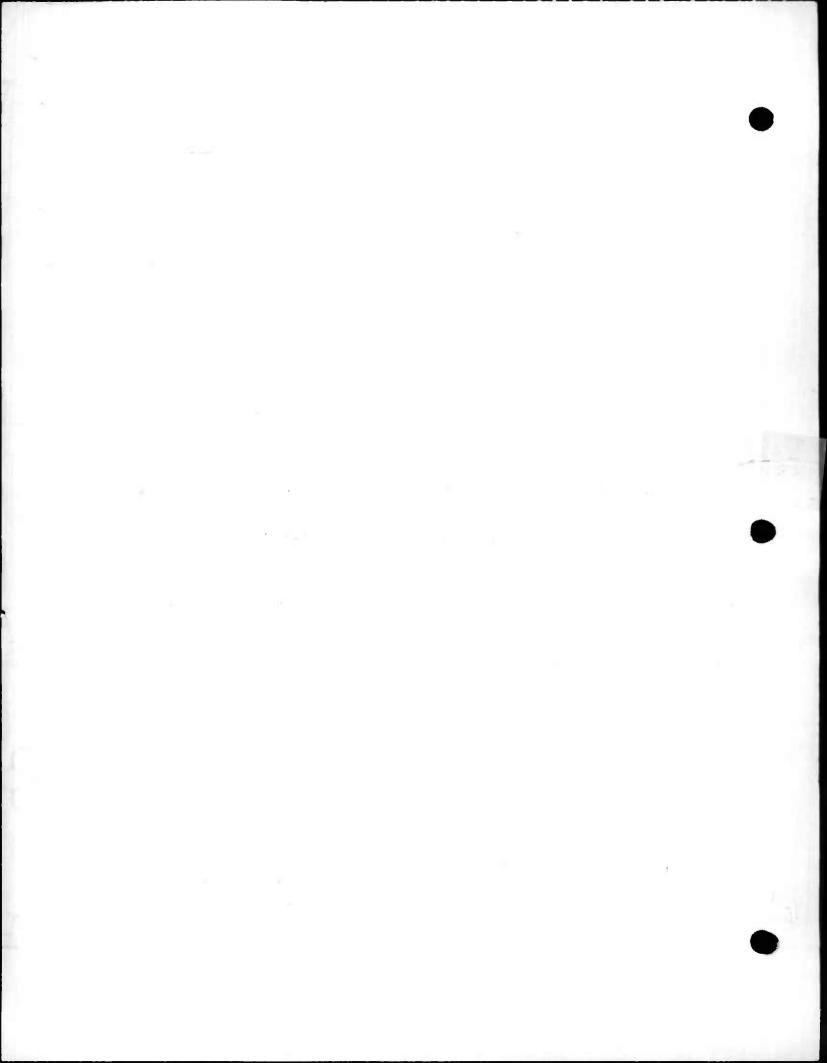
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) OBSTRUCTIVE PULHODARY DISEASE CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 1RONIC . Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24e. WAS AN AUTOPSY PERFORMED? 3 1 - YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☑ NO ☐ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1X Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 X NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 5 Pending Investigation 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 [X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 __ MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29g_LICENSE NUMBER BE OV IS April 13, 9 1995

8700 Georgia Avenue #400 Silver Spring, Maryland 20910-3605

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

32 REGISTBAR'S SIGNATURE



	_	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIE							
		1. DECEDENT'S NAME (First, Middle, JERRY	DEAN AYE	ERS			2. DATE OF DEATH ANONTH APPLIE	0 190	year 12:15 Am					
pinous		4. SOCIAL SECURITY NUMBER 215-52-6577 90. FACILITY NAME (If not institution,	1 🛣 M 2 🗆 F 📗 14	In yrs. lest birthdey) 6 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG . 1.0	,1948	BIRTHPLACE (State or Foreign Country) TENN .					
1, 2, 3 shc	ECTOR		ADVENTIST HOSPI	TAL		KVILLE	DEATH		Y OF DEATH FTGOMERY					
permit. Pages	DIR	10e. STATE 10b. CO	PRINCE GEORGES	18c. CITY	RELTS	SVILLE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
	FUNERAL	100. STREET AND NUMBER 11362 CHE	RRY HILL RD.		101	20705			N OF WHAT COUNTRY?					
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO NTES	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify san, Puerto Rican, etc.)		I. RACE — American Indian, Black, White, etc. Specify:					
27 Par or 10 Par	LETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	BEDUCATION grade completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT use	rork done during mo	ON est of working	BUSINESS/INDUS							
the hospital detached for	COMPL	12. FATHER'S NAME (First, Middle, Las		CAB	DRIVER	18. MOTHER'S NA	AME (First, Middle, Meldl		RTATION					
retained by 5 should be notified at	TO BE	CALVIN 190. INFORMANT'S NAME (Type/Print) DORIS AT	F. AYERS	19b. MAILING			Pours Number, City or To		BTREE					
6 may be ctor, page		20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 □ Cremation 3 □	Removal from State 20b.	PLACE AND DATE OF OTHER PLACE AND DATE OF THE PLACE AND DATE OF TH	F DISPOSITION (Na		OATE 20c.	LOCATION — CH						
ALT death. I funeral		21. SIGNATURE OF FUNERAL SERVICE LICENSEE MOOO91 M. W. CHAMBERS CO., RIVERDALE, MD. 20737												
within 24 hours at nipletely filled in by cremation, or removent, the medical		23. PART I. Enter the diseases shock, or heart fail iMMEDIATE CAUSE (Final disease or condition resulting in death)	ure. List only one cause on se	complications that caused the death. Do not enter the mode of dying, such as cardiac or respired. List only one cause on each line. a. Cardwhulmmay area DUE TO FOR AS A COMPROLUTING OFF										
.O. BOX 6870 certificate be executed ding physician and con tygiene prior to bunal,	ERTIFICATION	Sequentially list conditions, if sm, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in destrib LAST	b. Fulm DUE TO JOH AS A C. RI SICU DUE TO JOH AS A	CONSEQUENCE OF	selimo	ine a	wd D	ic ofur	24hrs.					
he death the atten Mental H	CAL CEF	PART II. Other significent conc	d. ////////////////////////////////////	ut not resulting in	n the underlying	ceuse given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS					
amy that	MEDI	DID TORACCO USE CO	ONTRIBUTE TO CAUSE OF	E DEATH VE		LINICEDTAL	1 🗆 YES	2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO					
N: The law ficate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 W NO	HOSPITAL:	8. PLACE OF DEAT	H (Check only one) OTHER:									
NG PHYSICIAN: The first this certificate sath with the State marked, or item		27. MANNER OF DEATH 1 Netuzel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c, INJI	URY AT	6 Other (Specify) 28d. DESCRIBE HOW	/ INJURY OCCUP	RED					
TTENDI CTOR: A after de	ETED BY	3 Suicide 8 Could no	Investigation											
	COMPLE		PHYSICIAN: To the best of my knowle											
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE	29b. SIGNATURE AND TITLE OF CERT	VI Voyek	M.D		29c. LICENSE NU		1	IGNED (Month, Day, Year)					
9 ,,	TO	20 NAME AND ADDRESS OF PERSON RAKESH V	N WHO COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print) Old	Georg	retorm L	ed. K	ock ville					
2+1		31. DATE FILED (Month, Day, Year) ADD 2.1 1995	July Davelor he	roally		- 0			MD 20822					

. . . VOV any and a second

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 75 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

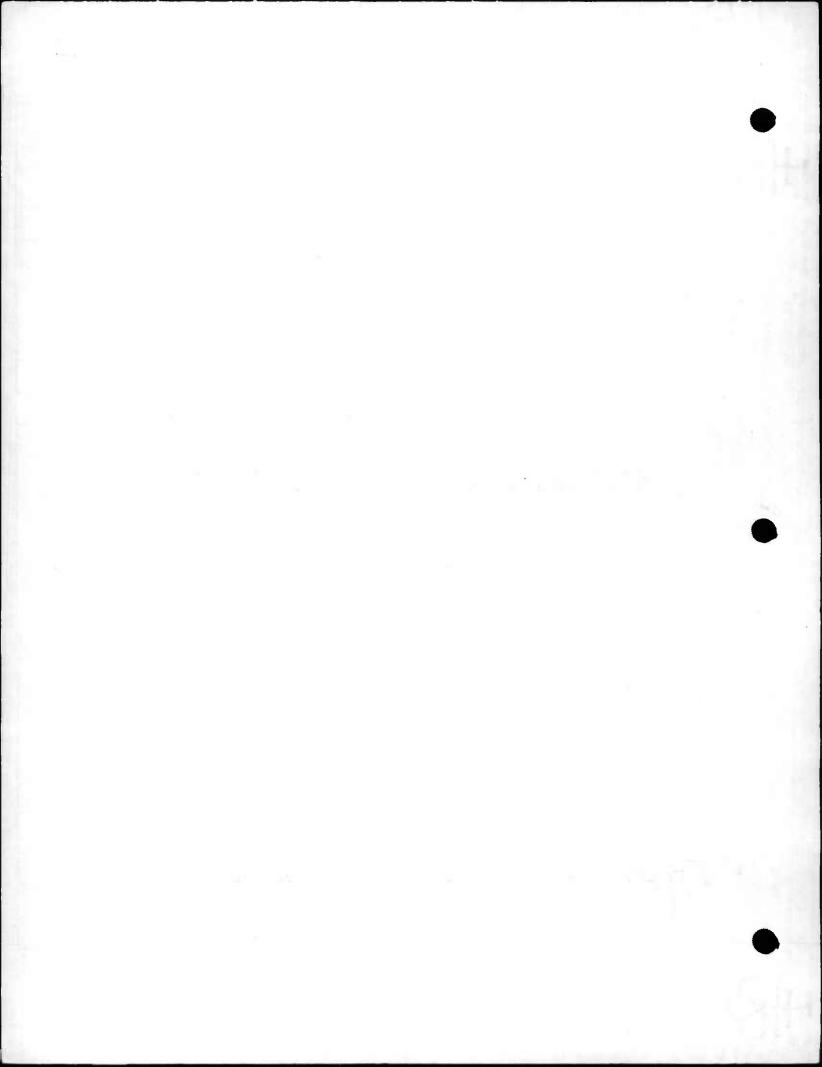
	1 - STATE REGISTRAR	SIMIE UF N			ICATE				MEN I/	REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last)	REFUGIO							2. DAT	E OF OEATH			3. TIME OF OEATH	
	SISTER MARIA RE	AUGIO ANO	GUL0						Api	il 18,	199	5 YEAR	4:45 P.M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER		IF UNDER		7. DATI	E OF BIRTH			PLACE (State or Foreign	
	212-84-6438	1 🗌 M 2 🏋 F	53	YRS.	MONTHS	DAYS	HOURS	MIN.		y 1, 1	941	Mex		
	9a. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY,	TOWN O	R LOCATE	ON OF OR				INTY OF O		
6	19101 Georgia Ave	nue			Bro	ookev	vill	e			Мо	ntgor	nery	
ᇤ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v		10c CIT	Y, TOWN O	D I OCATI	ION					T		
DIRECTOR		gomery			ookev								10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	Somery			OOKC		ZIP COO	F			10a CIT	TIZEN OF W	1 X YES 2 NO	
8	19101 Georgia Ave	nue. P O	Box 220)		1	208						States	
FUNERAL	11. MARITAL STATUS	12. WAS OECEOEN	T EVER IN U.S. ARM	EO	13. 1	WAS OECE			NIC ORIG	IN? (Specify Yea			- American Indian,	
	1 X Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 NO)	1 1	yes, spe	cify Cuba	n, Mexice	n, Puarlo	Ricen, atc.)		Black	, White, atc.	
ě	3 Widowed 4 Divorced	1						-,,,,		Spanish		- Opera	Spanish	
COMPLETED	15. OECEOENT'S EDU- (Specify only highest grade	CATION completed)	(Give	e kind of	Work done of	CCUPATIO	N it of workin	197	16	b. KINO OF BUS	SINESS/INC	DUSTRY	W.	
픠	Elementary/Secondary (0-12)	College (1-4 or 5+	•)		se retired.)									
M M	12 17. FATHER'S NAME (First, Middle, Last)		Ke1	1g1	ous V	vomar				Roman C		lic (Church	
	Gerardo Angulo									Middle, Malden				
BE	19e. INFORMANT'S NAME (Type/Print)		106	ALAU INC	1 Oonsse	(Short or				Luz Br				
2	Sister Luz Castro	0											eville, MD	
	20a. METHOD OF DISPOSITION	_	20b. PLACE AN					• • 1	-			City or To		
	1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	Gate c	atory or o	ther place)			27.7	1				ng, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENDEE	O	/1 11		NAME AN			CILITY	.1 511	vel	SPLII	ig, Maryiano	
1	In deed	X		Hines-Rinaldi Funeral Home,								Inc.		
	23. PART i. Enter tha diseases, or	condications that	coursed the dear	th Do	11	1800	New	Ham	pshi	re Ave	., S	ilvei	Spring, MD	
	anock, or naart failure.	List only one cau	se on each line.		iot aintei	tita moo	e or dy	ng, suci	II SS CA	rulac or respi	ratory sn	rest,	Approximate Interval Between	
	iMMEDIATE CAUSE (Final disease or condition	00	101	10	2 _		1	+-					Onset and Death	
ı	resulting in death)	a. OUE TO	(OR AS A CONSEOL	JENCE O	DON D:	- 1 m	نام ا	214	N.		reast 100			
_		(accir	0	ma	0	J '	9/2	p Y	s rea	N		104Rass	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A CONSEOL	ENCE O	F):		1		- 1	5 1 0)	
CA	cause. Entar UNDERLYING CAUSE (Disease or injury	C					U							
E	that initiated events	OUE TO	(OR AS A CONSEOU	IENCE O	F):									
EH	resulting in death) LAST	d												
	PART II. Other significant condition	s contributing to	death but not rea	auiting	in the un	dariving	cause o	iven in	Part i.	24a, WAS AN	ALITOPSY	24h	WERE AUTOPSY FINGINGS	
DICAL								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR	MEO?	/	MAILABLE PRIOR TO COMPLETION OF CAUSE	
MED									-	1 🗆 YES 2	Ø NO		OF OEATH?	
_ [DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEAT	H YE	S \square N	NO ID	LINC	ERTAIN		1			1 TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	MIDOTE TO CAL			TH (Check o		0140	LKIAII	10					
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	DOA	OTHER 4 Nurs	t: Ing Home	5 12/80	aldence	6 Oth	er (Specify)				
Ŧ	27. MANNER OF OEATH	28s. OATE OF	INJURY	28b. TIM	E OF	28c. INJU	RY AT			SCRIBE HOW II	NJURY OC	CUREO		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	lly, Year)	INI	M	1 Y	IK? ES 2 [NO						
	3 Suicide 6 Could not be	28s. PLACE Of	F INJURY — At hometc. (Specify)	e, farm, :	street, facto	ory, offica			28f. LO	CATION (Street a	nd Number	or Rural R	oute Number,	
=	4 Homicide determined		etc. (opecary)						City	or Town, State)				
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, deat	h occum	ed at the th	me, date a	and place,	and dua	to the ca	ruse(a) and man	ner as sta	ted.		
No.	one) 2 MEOICAL EXAMINE												and menner as stated.	
	296. SIGNATURE AND TITLE OF CONTIFIER							NSE NUM					(Moreth, Day, Year)	
BE	Usna. Votre	do M	0		D11200 + 4/19/95									
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUS	SE OF OEATH (ITEM	27) (Type	, Print)		-	10		2		4.	111-	
	12001 te	ripra.	Abe 1	1 (1	reat	on	/\	la		2090	6			
	31. DATE FILEO (Month, Day, Year) ADD 2.1 1995	22 BEGITERA	TE POSTULE	Randul										
- 4	APR GI MMI AP	A 40												

DIVISION OF VITAL RECORDS, P.O. BOX 68760, A BALTIMORE, MARYLAND 21215-0020

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		HEGIOTIVAL				OLITIII	IUAI		DEA	In		HEG. NO.			
		1. DECEOENT'S NAME (First									2. DATE O	F DEATH DA	·	YEAR 3.	TIME OF DEATH
		Albert I	Louis A	Andrew							Apri			995	3:15 A M
		4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In y	rs. last birthday		R I YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH		8. BIRTHPL	ACE (State or Foreign
_		212-19-211	3	1 💢 M 2 🗌 F	38	YRS.	MONTHS	DAYS	HOURS	MIN.	5/15	756		Grena	ada
port		9a. FACILITY NAME (If not institution, give street and number)					9b. CIT	Y, TOWN	OR LOCATI	ON OF DE			9c. COUN	TY OF DEA	гн
2, 3 should	腾 등	7017 Mayfair Road					Li	aure	1				Prin	ce Ge	orge
	DIRECTOR	RESIDENCE OF DECEDENT										0290			
ades	H	10a. STATE 10b. COUNTY			1	10c. CITY, TOWN OR LOCATION							10	d. INSIDE CITY LIMITS?	
±:	FUNERAL DI	MD	Prir	ice Georg	<i>j</i> e	L	Laurel						1	YES 2 NO	
реги		100. STREET AND NUMBER		-					Of. ZIP CODI						T COUNTRY?
physician. burial-transit permit. Pages		7017 Mayfa	air Roa	aa					20707	/			Grei	nada	
sicial ial-tr		11. MARITAL STATUS		12. WAS DECEOER FORCES?	T EVER IN U.	S. ARMED	13.	WAS DE	CENDENT C	F NISPA	NIC ORIGIN?	(Specify Yea	or No-	14. RACE -	American Indian,
bu b	BY F	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE			NO If yes, specify Cuben, Maxican, Puerto 1 YES 2 NO Specify:				The second secon		Specify:	Vhita, atc.	
al or attending for use as the	8	3 Wildows 4 Dive	orced												Black
afte use	ш		EDENT'S EDU		16	Give kind of			ION lost of working	na	16b. I	KIND OF BUS	INESS/INDU	ISTRY	
for for		Elementary/Secondary (0-12)	College (1-4 or 5		life. Do NOT	use retired.)			•					
the hospit detached once.	COMPL	12				Nursin	g Ass	sist	ant		He	ealth	Care		
the hos detach once.	8	17. FATHER'S NAME (First, M							18. MOTI	NER'S NA	ME (First, Mi	ddle, Maiden	Sumame)		
d be	اسا	Not Availa	mre							roti	hy And	arew			
after death, Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-tranmoval.	5 B	19a. INFORMANT'S NAME (r, City or Town		Code)	
De rel	=	Brenda Dav	ris			7017	Mayfa	air	Road/	Law	rel/M	2070	7		
nay be page		20a. METNOO OF DISPOSIT t X Burlei 2 ☐ Cremetic			20b. PL	ACE ANO OATE	OF DISPO	SITION/A	leme of		OATE	20c. LO	CATION — C	ity or Town	, Stata
after death, Page 6 ma by the funeral director, p emoval, Ilcal examiner must		4 Donation 5 Other		ovel from State	- Mar	ry, crematory or vland	Nat	1 Me	em Pa	rk	4/1	4 T.a	urel	MD	
Pag al dir		21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
death. Pag tuneral di J. examiner		> MM	111.	U4. m/	OK	2.,	-	Adv	ent M	iemo:	rial S	Servic	es		
the day	Н	11001	une	une Vo	24)	ru					D 2140				
1 - 1 - 1 S		23. PART I. Enter the d ahock, or h	liseases, or o	complications the List only one car	at codsed th	ne death. Do	not ente	r the m	ode of dy	ng, suc	ch ss cardle	ac or raspli	ratory arre	st,	Approximata
illed in or	1 1	IMMEDIATE CAUSE (Final											Interval Between Onset and Death		
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completely filled fall, cremation, or event, the m		DUE TO (OR AS A CONSEQUENCE OF):													
executed within and complete to burlal, crem; matic event,	z			CNS	GOXOT	lasmos	is								1 YR
e be execut sictan and c nior to burit traumatic	CERTIFICATION	if any, laading to immediata OUE TO (OR AS A CONSEQUENCE OF):											1 211		
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endin	ᇤ	resulting in death) LAS	T	d											
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The last te De te De	SICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL					26. P	PLACE OF D	EATN (Ch	eck only one				
AN: ifficat s Sta	Sic	1 TES 2 NO		HOSPITAL:	ER/Outpatia	int 3 🗆 DOA	OTHE 4 I Nu	R: mina Hor	me 5 XRe	aldenca	6 Other	(Specify)			
Cert th th	РНУ	27. MANNER OF DEATN		28a. OATE OF	INJURY	28b. TI	ME OF	28c. IN	JURY AT			RIBE NOW IN	JURY OCC	PRED	
r this h wit			Pending Investigation	(Month, L	Jay, Year)		IJURY M		ORK? YES 2	NO					
Afte deat	ВУ	A C Salata	Could not be	28e. PLACE C	OF INJURY —	At home, term,	atreet, tec				28t, LOCAT	TION (Street a	nd Number o	y Rural Rou	n Number
TTEN TOR: after	COMPLETED	4 Homicide	determined	building,	atc. (Specify)							Town, State)		7 (0/0/ 1/00	o ridiribus,
OURS OURS	9	29a. CERTIFIER				-	_							_	
TAL TAL	A I	(Check only		CIAN: To the best of											
OSP! UNEF ithin	[중	2 L MED	ICAL EXAMINE	H: On the basis of a	xamination ar	nd/or investigat	lon, In my	opinion,	death occur	ed at the	time, data a	nd placa, and	d dua to the	cause(a) a	nd manner as stated.
H H H B B B B B B B B B B B B B B B B B	111-	SIGNATURE AND TITLE	OF CERTIFIER	1	44 K				29c. LICE	NSE NU	MBER,				onth, Day, Year)
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traur	TO 8	「いくなく」	Jup	muil		*			194	157	10.	C.	▶ 4/	14/9	5
	F	30 NAME AND ADDRESS OF									1				
		1701 14th		Washing	ton D.	.C. 200	009								
		31. DATE FILED (Month, Day, APR 2	1005	32. BEGISTR	AR'S SIGNATU	JRE									
		APK 2	0 1995	Julia d	auctor	Kardall									



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physician.	ctor, page 5 should be detached for use as the burial-transit	
attending	use as the	
withings hours after death. Page 6 may be retained by the hospital or attending physician	tached for	
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retained	5 shoul	
nay be	; page	
Page 6 r	director	
death.	funeral	
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ry hour	filled in	ion. or r
within	mpletely	сгеттав
be executed with	and co	o burial
icate be	the attending physician and completely filled in by the funeral director, pag	e Drior 1
he death certificate b	tending t	il Hvdien
he dea	the att	Мелtа

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

irmit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the host TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

3

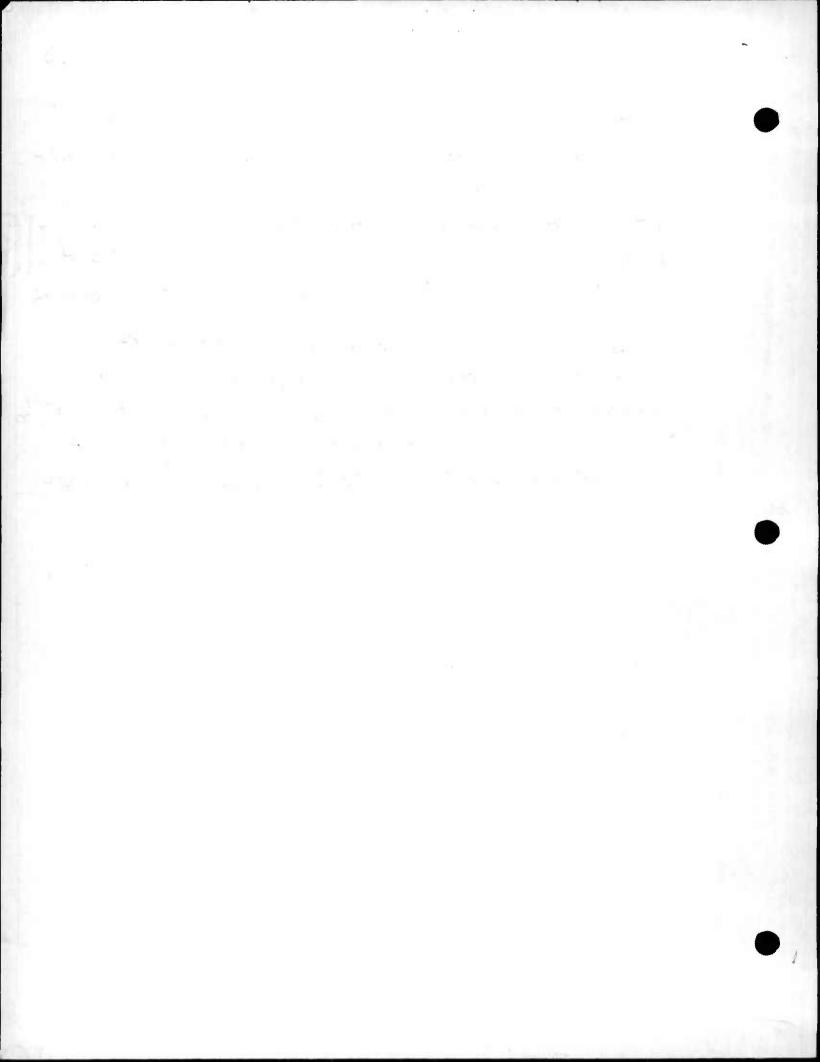
							95	13673
	REGISTRAR	STATE OF MARYLAND	DEPART ERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last) A BRON	LEE		Aye	ers	2. DATE OF OEATH		3. TIME OF DEATH
	000 01 0-0	6. AGE (In yrs. In		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
ا ا	9a. FACILITY NAME (If not institution, give stree PENINSULA REGIONA	Line		SALIS	R LOCATION OF DE		9c. COUNTY	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATI	ON			10d. INSIDE CITY LIMITS?
-	10e. STREET AND NUMBER	COMACK		PAIN 101.	ZIP CODE		10g. CITIZEN	1 ★ YES 2 □ NO OF WHAT COUNTRY?
FUNERAL		PSBURG AT 2. WAS DECEDENT EVER IN U.S. AF		Tio has been	234			U.S.A
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2		If yes, spe	city Cuban, Maxica 2 NO Specify	HC ORIGIN? (Specify Yearn, Puerlo Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: BLACK
LETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) (G	live kind of wor . Do NOT use		t of working	16b. KIND OF BUS	BER	
OMPLET	17. FATHER'S NAME (First, Middle, Last)		BA	RBEA		ME (First, Middle, Meiden		
BE C	HARON 194. INFORMANT'S NAME (Type/Print)	HYEN			MAR	GARET	UPS	
2	FANNIE M.	HYERS	5. MAILING A	DDRESS (Street and	ODS bar	Route Number, City or Town	a in	ter, Va 2342
	20a METHOD OF DISPOSITION 1 Buriel 2 Cremetton 3 Remove 4 Donation 5 Other (Specify)	MT.	AND DATE OF matory or othe	DISPOSITION (Nem	CH CEM.	1	EXMO	or Town, Stata RE, VA.
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		G LDDE	ADDRESS OF FACE	MEDAL	HOME ER. V	4 23420
	IMMEDIATE CAUSE (Finei	nplications that caused the de it only one cause on each line	eath. Do not	entar the mod	le of dying, aucl	n ea cerdlec or reepi	retory arrest	Approximata Intervei Between Onset and Daath
	disease or condition resulting in death) e	DUE TO (OR AS A CONSE	OUENCE OF):	ARRES	T FRWM	META STAT	IC CA	
ION	Sequentielly list conditions, if any, leading to immediate	METTISTATI	C Sa	UAMOUS	cecc c	ARUNOMI	4 OF	
FICAT	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	P TONSIL DUE TO (OR AS A CONSE	WITH	+ LIVE	er i b	ONE INV	olvem G	~ <i>T</i>
CERTIFICATION	resulting in death) LAST	ALSO CHANT	c AH	frest				
	PART II. Other algnificant conditione of	ontributing to deeth but not i	reculting In	the underlying	cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
MEDICAL	CHRONIC DISEA.	SE AN EMIA				1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N.	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF DEA	TH YES	No 🗆	UNCERTAIN			1 Nes 2 No
PHYSICIAN:		IOSPITAL:		(Check only one)				
HYS	1 YES 2 NO 1	Impetient 2 ☐ ER/Outpetient 3 28e. DATE OF INJURY		☐ Nursing Home		8 Other (Specify) 28d. DESCRIBE HOW II	HILIDA OCCIDI	
ву Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WOR 1 YE	K? ☐ NO	200. DESCRIBE HOW II	SORT OCCUR	
	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At he building, etc. (Specify)	me, farm, atre	et, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or R	lural Route Number,
COMPLETED		N: To the best of my knowledge, de On the bests of examination and/or						use(a) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	like MO			29c. LICENSE NUM			GNEO (Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH (ITE				6 MARYLAND	,	-
	MICHAEL.	J. KELLENE	RI	MD	106 MIL	FORD ST	SALIS	BURY MO

MICITALES

31. DATE FILED (Month, Day, Year)

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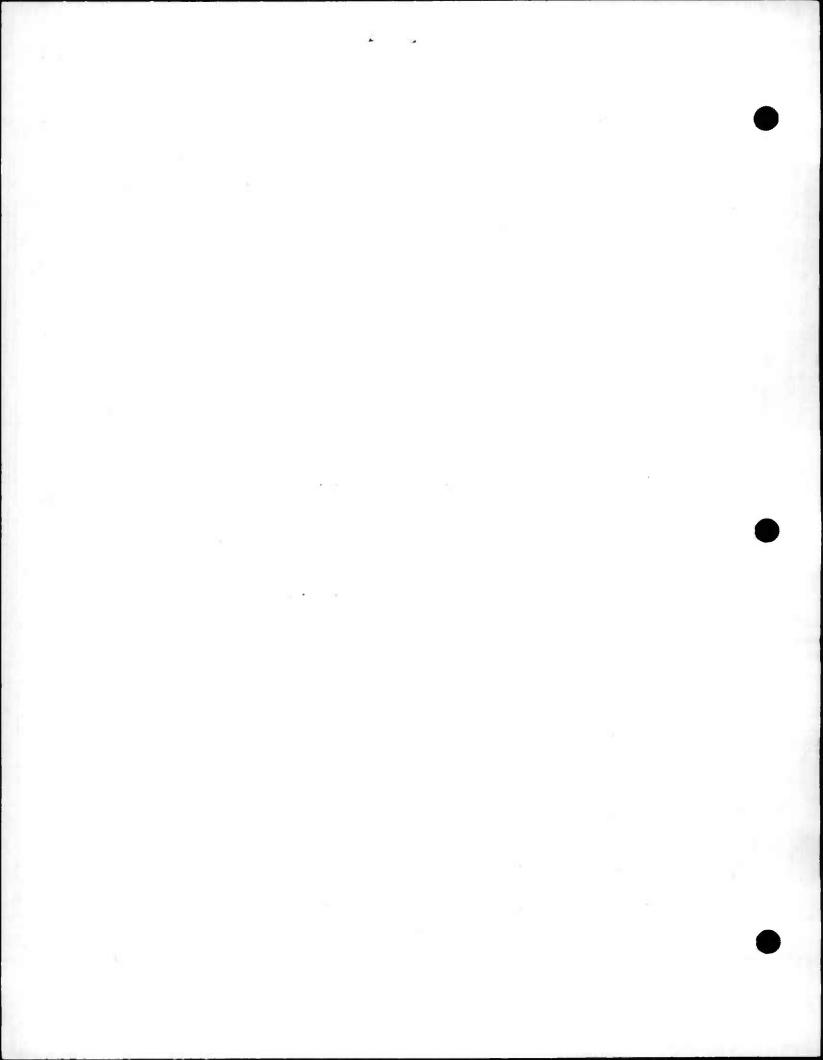
white timber forder



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO				
		PECEDENT'S NAME (First, Middle, Last)	olan f	Aller			2. DATE OF DEATH	1995	3. TIME OF DEATH		
1			8. AGE (1	In yrs. lest birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-20-193	8. Bil Co	RTNPLACE (State or Foreign unity)		
. 2, 3 should	ECTOR	90. FACILITY NAME (If not institution, give stree HOLT TOTAL MPM OF RESIDENCE OF DECEDENT	ial Hospita	ul	1	PLOCATION OF DE	atn Cace	Sc. COUNTY O			
ages	DIREC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d, INSIDE CITY		
jį.		MD Ha	arford			re de Gr	ace		1 TYES 2 NO		
physician. burial-transit permit. Pages	FUNERAL	1000 Morrison E	Blvd.	1110 171100		21078			USA		
attending physician. se as the burial-tran	B⊀	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	If yes, spo	ecify Cuban, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yee n, Puerto Rican, atc.)	В	ACE — American Indian, lack, Whita, aic. Decity: White		
al or	PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade core Elementary/Secondary (0-12) 1 2	mpleted) College (1-4 or 5+)	(Give kind of a life. Do NOT us	Chi	st of working			vernment -		
e de Pe	COMPL	17. FATHER'S NAME (First, Middle, Last)		veteran	5 Carrie		ME (First, Middle, Maiden		ospitai		
2 2 K	BE	Richard Harry 190. INFORMANT'S NAME (Type/Print)	Allen				<u>ra Mae Win</u>				
5 5	임	Mrs. Linda L. Alle	en				Poute Number, City or Town Havre de (
ector, page		20a, METHOD OF DISPOSITION 1 □ Burial 2 X Cremation 3 □ Remova	I from State 20b.	PLACE AND DATE	DEDISPOSITION (No.	ment	DATE 200 LO				
		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN:	SEE R	R. A. Fe		Co., Inc		est Che	ester, PA		
0 -		► Wallow S	Small		Mitche Havre	ell-Smith de Gra	Funeral H	21078-3	P.A. 197		
ad within 24 hours after ompletely filled in by the compation, or remove event, the medical		23. PART i. Enter the diseases, or comehock, or heert fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	ACUTE	ch ilne.	cion u		YOCARDIA		Approximate interval Between Onset and Death		
e be executed sician and com rior to burial, ctraumatic ev	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (DISEASE (DISEASE CAUSE (DISEASE (DISEASE (DISEASE (DISEASE (DISEASE (DISEASE (DISEASE (DISE									
th certificat ending phy I Hygiene p or other	CERTIFICATION	CAUSE (Disease or injury that Initiated events resulting in deeth) LAST CAUSE (Disease or injury that Initiated events resulting in deeth) LAST CAUSE (Disease or injury that Initiated events) CAUSE (Disease or injury that Initiate									
quires that the dear n signed by the att Health and Menta	EDICAL (PART II. Other significent conditions c	contributing to deeth bu	ut not resulting I	n the underlying	ceuee given in	Part I. 24a. WAS AN PERFOR 1 YES 2	IMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
beer of		DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	F DEATH YE	S I NO II	UNCERTAIN	100		1 🗀 YES 2 🗀 NO		
The lange te has ate Deg	PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEAT	N (Check only one) OTHER:	5 Residence					
PHYSICIA this certil with the rked, or	PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		JRY AT	28d. DESCRIBE NOW IN	JURY OCCURED			
After death	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a, PLACE OF INJURY building, etc. (Specif	— At home, term, a		ES 2 NO	26t, LOCATION (Street a City or Town, State)	nd Number or Run	al Route Number,		
OR ATTEN DIRECTOR: hours after item 28 I	E I	4 Nomicide detarmined									
4 7 5 F	COMPLETE	(Check only one) 2 MEDICAL EXAMINER: C	N: To the best of my knowle						e(a) and manner as stated,		
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT:	O BE	296. SIGNATURE AND TITLE OF CERTIFIER	DO AT	TENDIN	6	14444	6 3	29d. DATE SIGN	8/95		
		JAY M.	ANG DO		BOUL	70N ST	- BEZI	AR R	10 21014		
		APR 1 2 1995	32. REGISTRAR'S SIGNA								



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete?	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremations, or	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the m	
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	e death certificate be executed withir all ours after death. Page 6 may be retained by the hospital or attending physician.	he attending physician and complete. [5] in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremator, or removal.	inv or other traumatic event the medical examiner must be notified at once
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<u></u>	executed withir	and complete	natic event
	certificate be e	the attending physician and complete: [64] in by the f Mental Hygiene prior to burial, crematic r- or removal.	r other traum
	e death	he atten Mental I	0 700

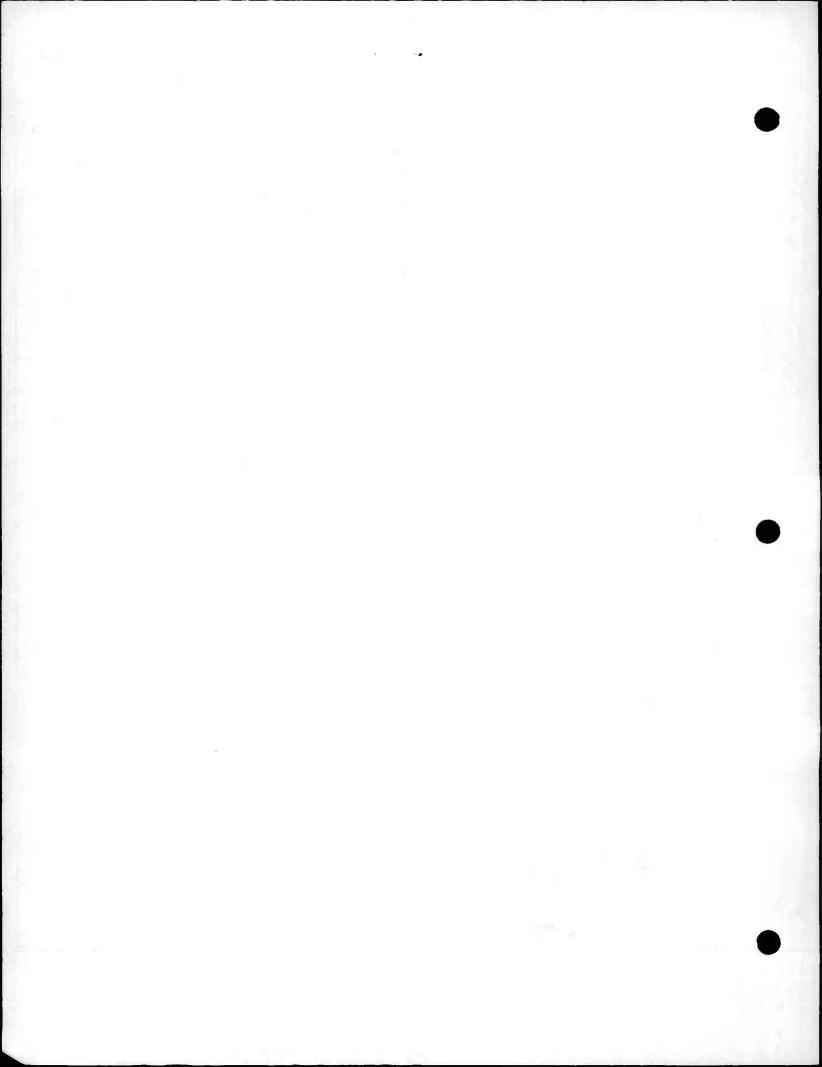
permit. Pages 1, 2, 3 should

re	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I
ISTRAR	CERTIFICATE OF DEATH

	FOR STATE REGISTRAR	STATE OF MARYLA		T OF HEALTH AND	MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, Last) SARAH	ODESSA	AMRE		2. DATE OF OEATH	AV VEAT	3. TIME OF DEATH 7:55 PM			
	4. SOCIAL SECURITY NUMBER			ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. Bil	RTHPLACE (State or Foreign			
	213-74-9702 9e. FACILITY NAME (If not institution, give st	-	YRS. MONTH	TY, TOWN OR LOCATION OF	5/19/19	03 M	aryland			
<u>m</u>	3955 Old R		30. 0	Street	ZEATH		arford			
6	RESIDENCE OF DECEDENT	-		Dorce		11	al rord			
FUNERAL DIRECTOR	Maryland 10b. COUNTY	Harford	10c. CITY, TOWI		reet		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
RAL	10e. STREET AND NUMBER	Daales Dasa		101. ZIP CODE	354		OF WHAT COUNTRY?			
N	11. MARITAL STATUS	Rocks Road 12. WAS DECEDENT EVER IN U	IS ARMED	3. WAS DECENDENT OF HISP	154		S . A . ACE — American Indian,			
BY FL	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, specify Cuban, Maxic	en, Puerto Rican, atc.)	В	lack, white, etc. pec/ly: White			
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade	ATION completed)	6e. DECEDENT'S USUAL (Give kind of work dor	OCCUPATION the during most of working	16b. KIND OF BU	SINESS/INDUSTR				
۳	Elementary/Secondary (0-12)	College (1-4 or 5+)		No. of the last of	7.7					
N N	17. FATHER'S NAME (First, Middle, Last)		House		AME (First, Middle, Maider	ome				
ö	William	Ne	eper	Sara			reett			
BE	19a. INFORMANT'S NAME (Type/Print)	210		SS (Street and Number or Rura						
2	Mary M. Amrei	n	3955A 0	ld Rocks F	Rd. St	reet,	Md. 21154			
	20. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remo	oval from State	ther place)	Name of cemetery, crematory of	1 4	OCATION City o				
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVISE LIC	Bel		. Gardens		I Alr,	Maryland			
	M. Blad	den hurt	6-111	Kurtz Fu	neral Ho sville. M		ð			
	23. PART i. Enter the diseases, or o	complicatione that ceueed	he death. Do not and				Approximata interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death)			hear of La	leis		Onset and Death			
	The second secon	OUE TO (OR AS	CONSEQUENCE OF):	, , ,			~ 7			
CERTIFICATION	disease or condition resulting in death) S. Conasture heart farling OUE TO (OR AS & CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CAT	cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):							
H	resulting in dieth) LAST	d								
CAL	PART il. Other significant condition	s contributing to death but	not resulting in the	undariying ceuse given i	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE			
					1 □ YES	2 NO	OF DEATH?			
2				_	_		1 123 2 10			
¥	25. WAS CASE REFERRED TO MEDICAL			28. PLACE OF DEATH (Check only one)					
Sic	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpet	fent 3 DOA 4 D	ER: lursing Home 5 Kasidene	8 Other (Specify)					
PHYSICIAN: MEDI	27. MANNER OF OEATH 1 Nature: 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	26c. INJURY AT WORK?	28d. OEŞCRIBE HOW	INJURY OCCURE	0			
BY	2 Accident Investigation	200 DI ACE OF IN HIDY	M	1 YES 2 NO						
TED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif)	/)	астогу, описе	28f. LOCATION (Street City or Town, State		ral Houte Number,			
COMPLETED	CONTROL ONLY	CIAN: To the best of my knowled					se(s) and manner as stated.			
	29b, SIGNATURE AND TITLE OF CERTIFIES			29c. LICENSE N			NED (Month, Day, Year)			
BE	Daves:	Dunn		032			11,1351			
5	30. NAME AND ADDRESS OF PERSON WH		H (ITEM 27) (Type, Print)				.,,,,,,			
	David S. Dui	nn 32. REGISTRAR'S SIGNAT	nibe	Bel Air	, Maryla	nd				
	31. DATE FILED (Month, Day, Year) APKI 2 1333	in a winder	13							



	* REGISTRAR				ICATE C							
	1. DECEDENT'S NAME (First, Middle, Las	,				, ,			REG. NO.	1		3. TIME OF DEATH
	Kermit Taylor B	rooks						04		2	95	16:40 p
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. last birthday)	IF UNDER 1 YE		UNDER 24 HRS.	7. DATE C	OF BIRTH Day, Year)		- 4	HPLACE (State or Foreig
	218-03-6665	1 🙀 M 2 🗌 F	85	YRS.	MONTHS DA	MR HOI	URS MIN,		27/19	09		rginia
	9e. FACILITY NAME (If not institution, give		96. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH				
DIRECTOR	Garrett County	al	0akland				Garrett					
E C	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	iTY		10c. CIT	10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY		19d. INSIDE CITY
1 8	Maryland	Garrett			Kitzmiller					LIMITS?		
AL	10e. STREET AND NUMBER	Garrett			K 1	10f. ZtP				10g. CITIZEN OF WHAT COUNTRY?		
EB	1185 Kitzmiller	Road, Bo	x 30,		21538				111			
FUNER	11. MARITAL STATUS	S. ARMED	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye									
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	I ©NO S						chy: White				
ED	15. DECEDENT'S Et (Specify only highest gra		16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working			16b.	KIND OF BUS	SINESS/INC	DUSTRY			
LET	Elementary/Secondary (0-12)	life. Do NOT u	e retired.)	g most or	HORNING							
COMPL	10	Stee	1 Make	r			Bet	hleh	am S	tee1		
8	17. FATHER'S NAME (First, Middle, Last)			16.	MOTHER'S NA	ME (First, M	liddle, Malden	Sumeme)				
H	Boise Brooks							-	Brook			
2	19e. INFORMANT'S NAME (Type/Print)			1			umber or Rural I					
-	Alverta Brooks			1185	Kitzm	ille	r Road	. Box	30.	Kitzr	nill	er. MD 21
	20e. METHOD OF DISPOSITION 1 N Burlet 2 Cremetton 3 Re	movat from State	20b. PL/ cemeter	ACE AND DATE	OF DISPOSITION	N (Name of	f	DATE	20c. LO	CATION —	City or To	own, State
	1 M Burlet 2 Cremetton 3 Removat from State 4 Donetton 5 Other (Specify) Kalbaugh Cemetery Apr 25, 95 Elk Garden, WV 21. SIGNATURE OF FUNERAL SERVICE LICENSEE											
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	, ,		22. NAM	E AND A	Burd	CILITY				
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attr	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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Dr. Thomas Johnson, MD 311 N.
31. DATE FILED (Month, Day, Year)

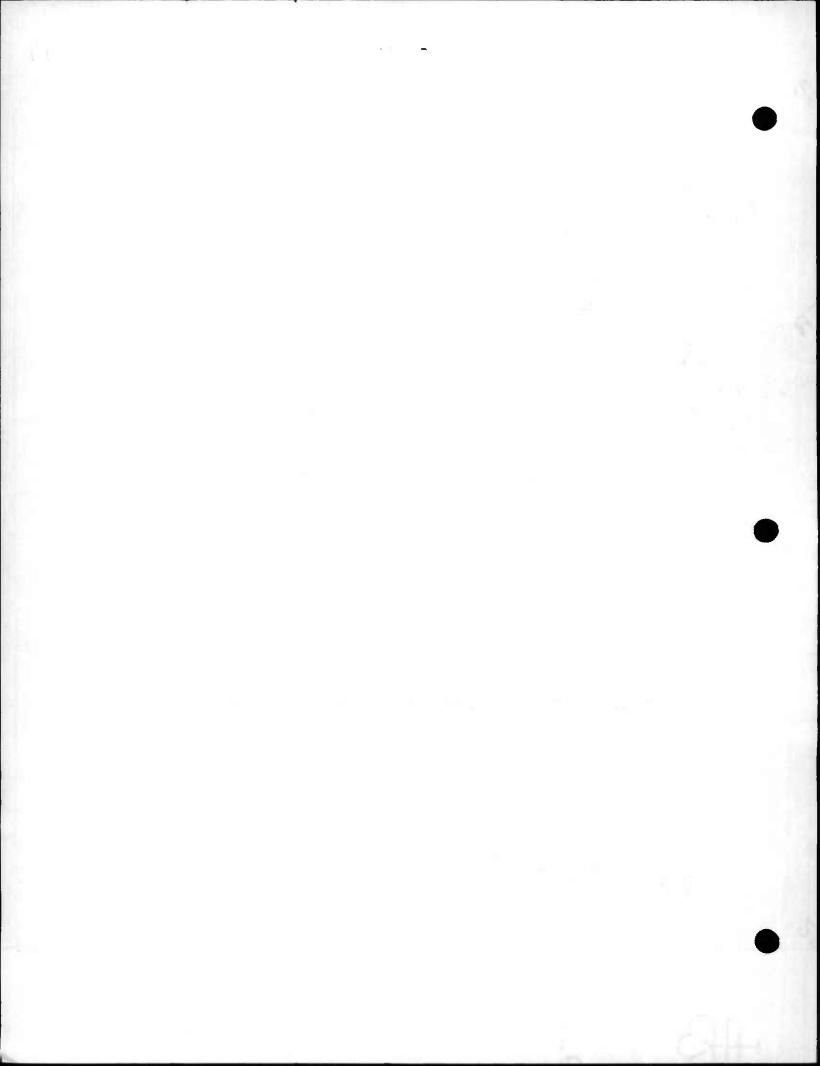
APR 1 9 1995

311 N.

Fourth St.,

Oakland, MD

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		1 - STATE REGISTRAR	STATE OF MARYL		DEPARTMEN RTIFICAT			MENTAL HYGIE REG. N	_		
		1. DECEDENT'S NAME (First, Middle, List)						2. DATE OF DEATH MONTH	3. TIME OF OEATN		
		Ruba Marie	BROADWATE	R				April 9	1995	7:45 P	M
		4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (in yrs. lasi i	//	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		BIRTHPLACE (State or Foreig	gn
2		217-14-0230	□ M 2 X F 71		YRS. MONTH		HOURS MIN.	Dec. 13,	1923	Maryland	
3	~	9e. FACILITY NAME (If not institution, give street				TY, TOWN	OR LOCATION OF OR	ATN	9c. COUNT	Y OF OEATH	
politic, rages 1, 2, 5 Should	DIRECTOR	Garrett County Memorial Hospital Oakland Garrett									
200		10a. STATE 10b. COUNTY			10c. CITY, TOWN	OR LOCA	TION			10d. INSIDE CITY LIMITS?	
		MD Garre	tt		M		ake Park			1 X YES 2 NO	5
	FUNERAL	10e. STREET AND NUMBER				10	1. ZIP CODE			N OF WHAT COUNTRY?	
	W	209 G Street						550	USA		
		11. MAR/TAL STATUS 12 1 Never Married 2 Married	. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNC	ED 13	I. WAS DEG	CENDENT OF NISPAN pecify Cuban, Mexica	IIC ORIGIN? (Specify Y	es or No- 14	 RACE — American Indian, Black, White, etc. 	
2	ВУ	3 X Widowed 4 Divorced IF YES, GIVE WAR OR DATES					1 YES 2 XNO Specify: Specify:				te
3	ED	15. OECEDENT'S EDUCATI		16a. DEC	EDENT'S USUAL	OCCUPATI	ON .	16b. KINO OF B	USINESS/INDUS		
	COMPLET	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4 or 5 +)			e kind of work done during most of working Do NOT use retired.)						
සේ		7			Waitr	ess		Re	estaura	ınt	
once.	8	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maide		_	
ed at	H	Irvin Roy	Hare	1			Bertha	Victo		Broadwate	r
notified	٩	19a. INFORMANT'S NAME (Type/Print) Carolyn E. Sander						Poute Number, City or To		ode)	
pe		204 METHOD OF DISPOSITION			D DATEOFDISPO			land, MD		ty or Town, State	
examiner must		1 N Burlai 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	1rom State cem	etery, crem	atory or other place	e)					
ner		4 Donetion 5 Other (Specify) Garrett Co. Mem. Gardens 4/12 Oakland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
cami		Stewart Funeral Home									
oval.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, Approximate									
or removal.		ahock, or heart fellure. List	iplications that caused conly one ceuse on e	the dea och line.	th. Do not ent	er the mo	ode of dying, auci	h aa cerdlec or rea	piratory erres	t, Approximate Interval Betw	
ion, o		IMMEDIATE CAUSE (Finel disease or condition								Onset and D)eath
event, the		resulting in death)	Cerebrova	scula	ar acci	dent				1 week	
al, cr	_	oue to (or as a consequence of): Diabetes mellitus					ye				
Hygiene prior to burial, or other traumatic ev	ŏ	Sequentially list conditions, b.	DUE TO (OR AS A							1,5	
trau	AT	cause. Enter UNDERLYING Hypertension								years	
ther	Ĕ	CAUSE (Disease or Injury that Initiated evente DUE TO (OR AS A CONSEQUENCE OF):									
Mental Hygiene	CERTIFICATION	resulting in death) LAST									
Wenta Jury,	0	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
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10 6	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 22 25. WAS CASE REFERRED TO MEDICAL									
State	3101	EXAMINER? HOSPITAL: OTHER:									
8 6	PHYS	1 ☐ YES 2 X NO									
marked		1 X Netural 5 Pending (Month, Day, Year) INJURY				W	ORK? YES 2 NO				
0 40	BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	— At hom	e, farm, street, fa			26f. LOCATION (Street and Number or Rural Route Number,			
after 28	딢	4 Nomicide determined determined						City or Town, Stat	or Town, State)		
hours	LET	29a. CERTIFIER (Check only) 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.									
CV ST	COMP	(Check only one) 2									
be filed within 7	- 1	296. SIGNATURE AND TITLE OF GETT FER 29d. DATE SIGNEO (Month, Day, Year)									
POF	BE	1					D15:		DATE S	4/10/95	
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH 3. TIME OF DEATH							
	GLADYS	APRIL 24.	1995	04:05 DM						
	4. SOCIAL SECURITY NUMBER 5. SE	111711111111111111111111111111111111111			7. DATE OF BIRTH (Month, Day, Year)		LACE (State or Foreign			
		M 2 X F 58	YRS. MONTHS	DAYS HOURS MIN.	Feb. 20.193		Penna.			
_	9a. FACILITY NAME (If not institution, give street an		9b. CITY, T	OWN OR LOCATION OF DE		c. COUNTY OF DE				
5	THE JOHNS HOPKINS	HOSPITAL	BA1	TIMORE CI	TY					
EC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY			
DIRECTOR	Pa.	York	Hallam	Bere: Twp.		- 1	LIMITS?			
AL A	10e. STREET AND NUMBER		10f. ZIP CODE		log. CITIZEN OF WI					
FUNERAL	Rd12 ,Box 154			174	06	u.s.	Α.			
2	11. MARITAL STATUS 12. W		S DECENDENT OF HISPAI	NIC ORIGIN? (Specify Yes or	Specify Yes or No— 14. RACE — American Indian, Black, Whita, atc.					
<u>A</u>	1 X Never Married 2 Married IF		YES 2 NO Specif		Specify					
	15. DECEDENT'S EDUCATION	16a DE	CEDENT'S USUAL OCC	IIPATION	165 KIND OF BUCK	COO (INDUOTOV	White			
	(Specify only highest grade comple	eted) (Gi	ve kind of work done due Do NOT use retired.)	ing most of working	16b. KIND OF BUSIN	ESS/INDUSTRY				
립	8		memaker				_			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Maiden Sur	mame)				
BE	C	Charles B	owman	Mar	ly McGu	rk				
2	19a. INFORMANT'S NAME (Type/Print)	196	MAILING ADDRESS (Street and Number or Rural	Route Number, City or Town, S	State, Zip Code)				
-	Teena M. Beck	The second secon		St., Dover,	Pa. 17315					
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of capetery, crematigny or other place), Susquenanna Mem. Gards. 4/28/95 York Twp., Pa.									
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE									
	Austin H. Eberly F. H. Inc.									
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate									
1 1	ahock, or heert feliure. Liet of	pations that caused the deanily one cause on each line.	nth. Do not enter th	e mode of dying, auc	h sa cerdiac or reepiret	tory arrest,	Approximata Interval Between			
	IMMEDIATE CAUSE (Fine)									
	disease or condition resulting in death) e. Left Ventricular anewrom. 5 week									
_	_	Sequentially list conditions b. Myozardial Infarction Zyews								
흔	DUE TO (OR AS A CONSEQUENCE OF):									
S	CAUSE (Disease or injury	COPON ENTY DUE TO (OR AS A CONSEO	arten	diseas	(e)		3 years			
	thet initiated events	DUE TO (OR AS A CONSEO	UENCE OF):							
CERTIFICATION	resulting in death) LAST									
ادا	PART II. Other eignificent conditions conf	tributing to deeth but not re	esuiting in the unde	orlying cause given in			VERE AUTOPSY FINDINGS			
일					PERFORME 1 □ YES 2 2		WAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDI						,	OF DEATH?			
ä	DID TOBACCO USE CONTRIBUT	TE TO CAUSE OF DEAT	TH YES AN	UNCERTAIN	v 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
YSI	1 YES 2 NO 1941	npetient 2 - ER/Outpetient 3		g Home 5 - Residence	8 Other (Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	INJURY	Bc. INJURY AT WORK?	28d. DEŞCRIBE HOW INJU	JRY OCCURED				
À	2 Accident Investigation	28e. PLACE OF INJURY A1 hor		1 YES 2 NO						
	3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Specify)	ne, term, street, tactor)	, omca	281. LOCATION (Street and City or Town, State)	Number or Rural Ro	ute Number,			
Ē										
COMPL	(Check only Christing Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
	One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
8	296. SIGNATUBE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 1992.8									
일	30. NAME AND ADDRESS OF PERSON WHO COM									
	Arthur Coday Jr. M.D. 600 North Wolfe Street Baltimore MD 212 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SONATURE WAY 0.9 1005									
	MAY 03 1995 /	diversor hardely								

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH April 1995 22 Albert 0 Dean Bailey 10:20 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month. Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign June 13, 1 😾 M 2 🗌 YRS. 249-62-3573 1932 South Carolina Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford 410 Breslin Road Joppa RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Joppa 1 TYES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? the funeral director, page 5 should be detached for use as the burial-transit 410 Breslin Road 21085 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 RACE — American Indian, Black, White, etc. 1 Never Married 2 1 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, atc.) BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced Specify: white ETED. 15. DECEDENT'S EOUCATION 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10 General Contractor Construction notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Elmo Baskin Bailev Lillie Cleo Barton BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Diane A. Bailev 410 Breslin Road, Joppa, Maryland pe 20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must 1 N Buriel 2 Cremation 3 R cometery, crematory or other place)
Holly Hill Cemetery □ Other (Specify) 4/26/95 Middle River, Maryland examiner 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 traumatic event, the medical 23. PART I. Enter the dise in and completely filled in by to burial, cremation, or remo that caused the deeth. Do not enter the mode of dying, such es cerdiec or reapiratory arrest, Approximsta shock, or heart fallure. List only one ceuse on each line Interval Batw IMMEDIATE CAUSE (Final Onset and Death diseese or condition resulting in desth) Hodikui /zyphna mos DIVISION OF VITAL RECORDS, P.O. BOX 68760 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if eny, leading to immediate been signed by the attending physician of. of Health and Mental Hygiene prior to ceuse. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST 0 PART II. Other significent conditions contributing to death but not reaulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY shows any NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate ha Hem HOSPITAL: 1 | YES 2 | 100 OTHER Inpatient 2 - ER/Outpatient DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) marked, or 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED M 1 YES 2 NO ВҰ After 1 death Accident Sulcide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) ETED. 28 Is 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be THE FUNERAL DIRECTOR: Item 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. THE HOSPITAL IMPORTANT: If 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee atated. 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 3092

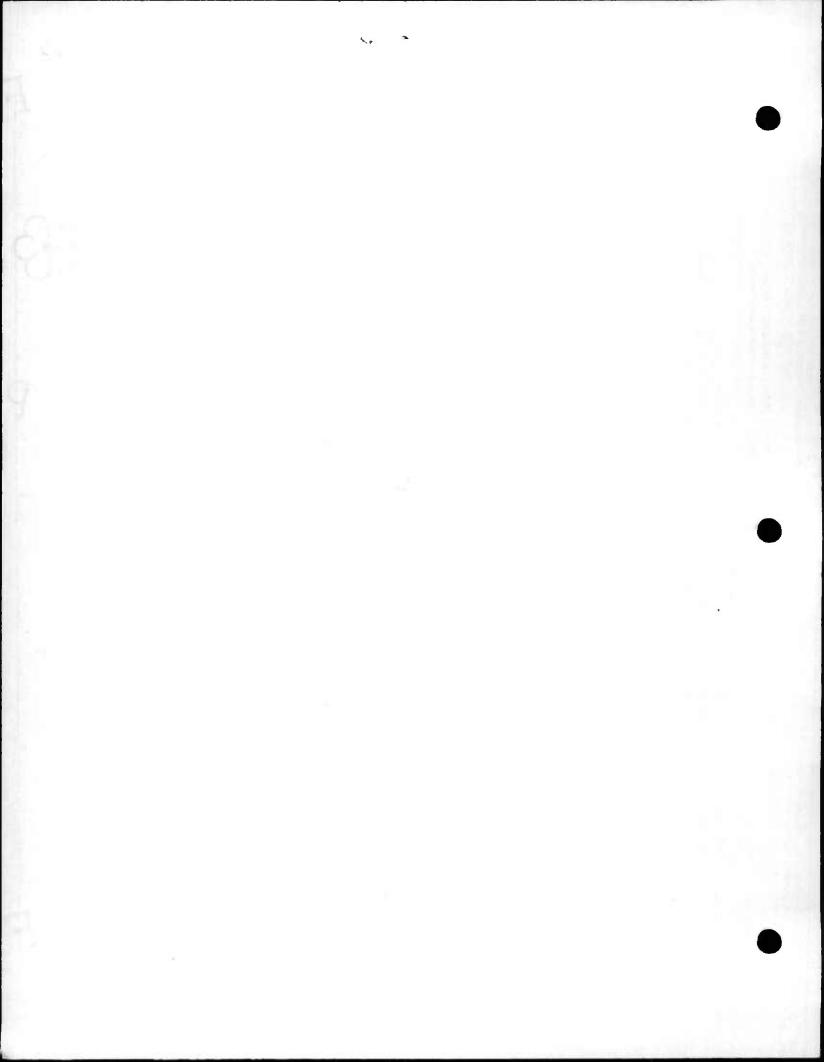
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6569

REGISTRARIS SIGNATURE

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2 4 1995

N. Charles



Pages 1, 2, 3 should

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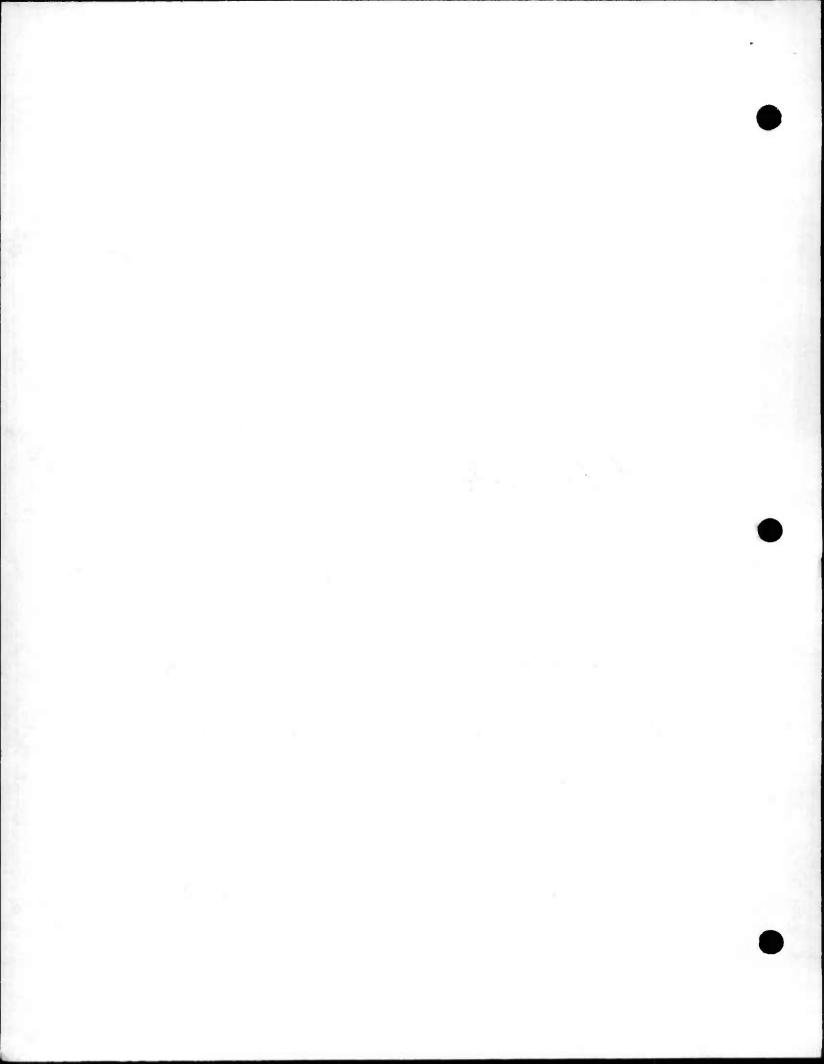
AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. REGISTRAR'S SIGNATURE ma disweller hardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH FAR 22 Kane Dowman 42ann 620 SOCIAL SEQURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) MARCH 7, 1 🗌 M 2 🖫 F DAYS HOURS 214-06-3875 1984 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL PASADENA 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 716 209th STREET 21122 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify. BY 3 Widowed 4 Divorced Specify: CAUCASIAN COMPLETED t6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) GLENN BOWMAN. JR. 86 LORETTA A. GRIMES 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LORETTA A. GRIMES SLAYBAUGH 716 209th STREET PASADENA, MARYLAND 21122 20a. METHOD OF DISPOSITION

1 X Burlal 2 Cremation 3 Removal from State
4 Donation 5 Debags. 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION - City or Town, State ery, crematory or other place)
JOSEPHS CATH. CH. CEM. Donation 5 Other (Specify) 4/25 TANEYTOWN, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ assilation resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other algorificant cogditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO thma COMPLETION OF CAUSE estary 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:
4 □ Nursing Home 5 □ Rasidence 8 □ Other (Specify) 1 Inputant 2 ER/Outpatient 3 I DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know riedge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the nation and/or investigation, in my opinion, death occured at the time, data and placa, 296. SIGNATURE AND TITLE OF CERTIFIER LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yea oski 22



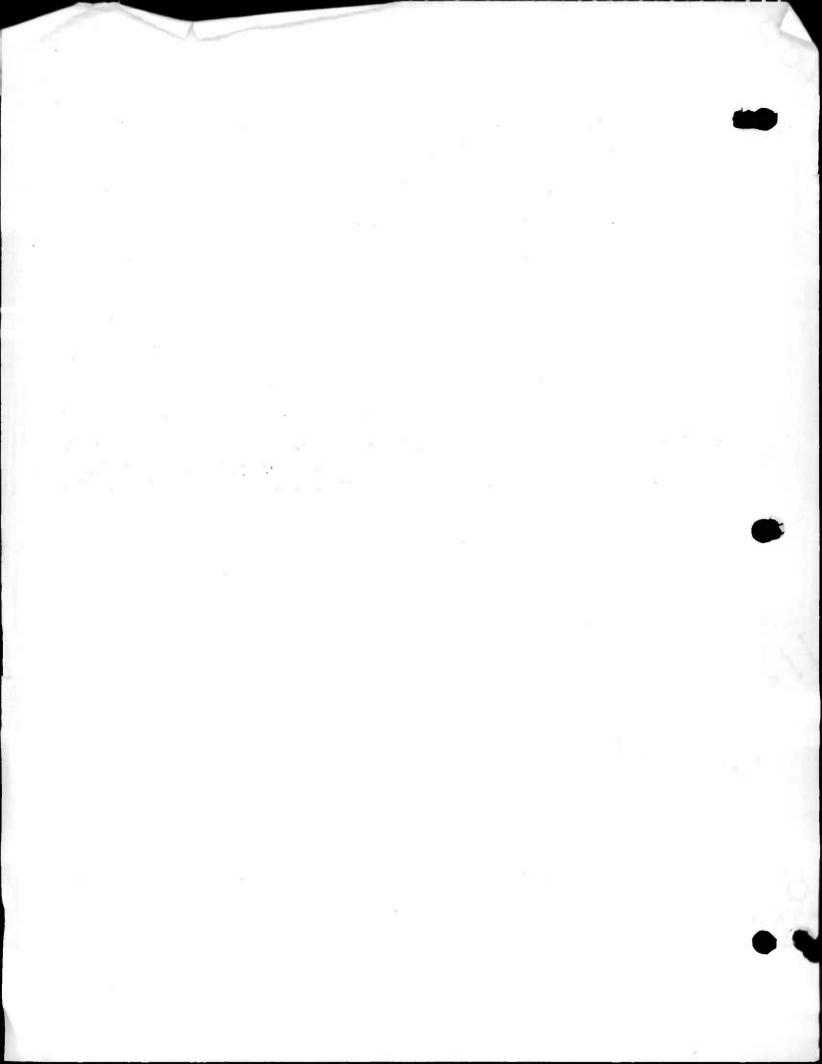
DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

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			1. OECEOENT'S NAME (First, Middle, Last) RUBIN	BERNST	EIN					2. DATE O	D/		EAR	3. TIME OF DEATH
	A		4. SOCIAL SECURITY NUMBER					_		APRI				12.156
			419-38-5377	1 M 2 F	AGE (In yrs. Ia	at birthday) YRS.	MONTHS 1	DAYS	HOURS MIN.	7. DATE OF	15,1	ه ۱۰	Country,	THUANIA
18	SHOUR		9a. FACILITY NAME (If not institution, give st				9b. CITY.	TOWN	OR LOCATION OF D		13,1	9c. COUNTY		
	6, 7,	TOR	HEBREW HOME OF	GREATER WA	ASHING	TON	R	оск	VILLE			MONTG		
	raffes	DIRECTOR	10a. STATE 10b. COUNTY	ONTGOMERY		10c. CITY	, TOWN OF		SPRING					10d. INSIDE CITY LIMITS? 1 P YES 2 NO
		ERAL	100. STREET AND NUMBER 1317 FENWICK LA	NE #1107	-			10	7. ZIP CODE 20910				N OF W	HAT COUNTRY? TATES
020 physician.	190-1	FUNE	11, MARITAL STATUS	12. WAS DECEDENT EV			13, W	AS OE	CENDENT OF HISPA	NIC ORIGIN?	(Specify Yes			- American Indian,
	5	BY F	1 Never Married 2 Merried 3 Never Married 2 Divorced	FORCES? 1 🔯		1 TYES 2X NO			pecify Cuban, Mexico	dexican, Puarlo Rican, atc.)			Bleck, White, etc. Specify: WHITE	
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the hospital or detached for u		APLET	Elementary/Secondary (0-12)	College (1-4 or 5 +) 5	lite	WHOLESALER						Y GOODS		
3 2	8 76	SE COMPL	17. FATHER'S NAME (First, Middle, Last) NATHAN BERNSTEI	N					18. MOTHER'S NA	OWN tt		,		
SALTIMORE, r death. Page 6 may be le funeral director, page al.	notified	TO B	19a. INFORMANT'S NAME (Type/Print) ASIA BERNSTEIN	ral Route Number, City or Town, State, Zip Code) 7-SILVER SPRING, MD. 20910										
	must be		20a METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remote 4 Donation 5 Other (Specify)	oval from Stata		AND DATE OF								
			21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. N	IAME A	NO ADDRESS OF FA					ELS, INC.
	COL .		Frank (Stone	>		11	70	ROCKVILL	E PIK	E-ROC	KVILLE	E,MD	. 20852
			23. PART i. Enter the diseases, or can shock, or heart fallure. IMMEDIATE CAUSE (Final	omplicatione that ce List only one ceuse	oused the d	eeth. Do n e.	ot enter i	the mo	ode of dying, euc	ch as cerdie	c or reepi	ratory erres	st,	Approximate Intervel Between Onset and Deet
= 3	L crematio		disease or condition resulting in death)		TROK AS A CONSE		7):							HTHOM I
executed within	burial,	N	Sequentially list conditions,)										
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_ 9	5 4	N.	DID TOBACCO USE CONTE	RIBUTE TO CAUS	E OF DEA	ATH YE	S N	10	2 UNCERTAI	N 🗆				
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IG PHYSIC	rked	ву РНУ	1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJI (Month, Day, Y	(bar)	28b. TIME INJU		W	JURY AT ORK? YES 2 NO	28d. DEŞCI	RIBE HOW I	NJURY OCCUI	REO	
OR ATTENDING PHYSICIAN: The law	after de	COMPLETED	3 Suicide 8 Could not be determined	28a. PLACE OF IN building, etc.	IJURY — At he (Specify)	ome, term, s	treet, tacto	ery, offic	ca	281. LOCAT City or	ION (Street a Town, State)	and Number or	Rural Ro	oute Number,
2 A A	hours	PE		CIAN: To the best of my	knowledge, d	eath occurre	d at the tin	no, date	and place, and due	to the cause	e(s) and man	iner as atated.		
SPITA INFRA	be filed within 72 ha	Ö	one) 2 MEOICAL EXAMINE	R: On the besis of exami	Ination and/or	investigation	n, In my op	olnion, d	death occured at the	time, data a	nd place, an	d due to the o	:ause(s)	and menner as stated.
¥ ±	ORTA	BE	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NU					Month, Day, Year)
5 5	₹	5	Calumy,		NF 00				D 365	32		APR	JL	16 1995
	}		P. TALWAR, 612	O COMPLETEO CAUSE O MONTE 32. REGISTRAR'S	-OSE	RD ,	Print) ROC	LKI	nlle.					
			31. DATE FILED (Month, Day, Year) ADD 1 9 1005	32. REGISTRAR'S	SIGNATURE									
	- 1	13	700 EQ 100E	Chille Martels	DATE OF THE OWNER	- II.								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

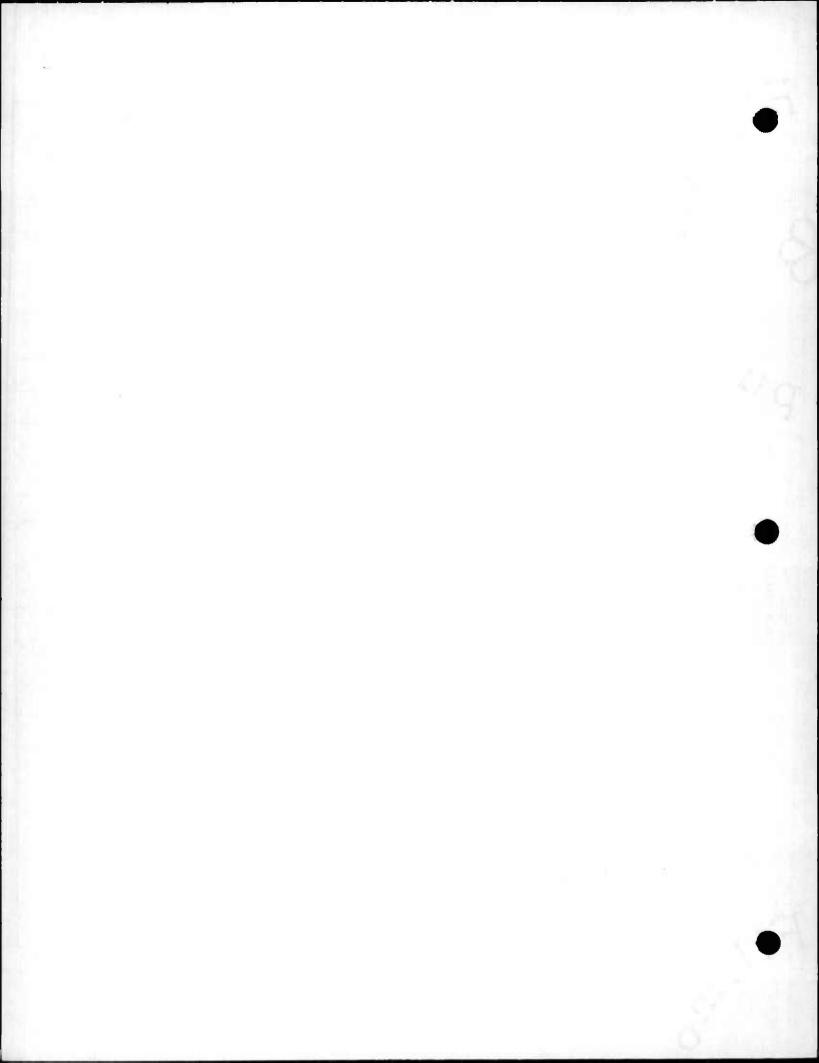


DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

			Doris 4. SOCIAL SECURITY NUMBER		Baker				MONTH /	10,19	95 3	3: TIME OF DEATH 3: 30 PM	
			217-14-7086	1 M 2 🕸 F	NGE (In yrs. leet	YRS. MON	THS DAYS	IF UNDER 24 HRS. HOURS MIN.	NOV.	w Wanel	Country)	Sylvania	
	should		9a. FACILITY NAME (If not institution, give s	treet and number)		9b.	CITY, TOWN O	R LOCATION OF			OUNTY OF DEA		
	. 2, 3	TOR	3413 Dunnington F	load		В	eltsvi	lle		Pri	nce Ge	orges	
	permit. Pages	DIRECTOR	Maryland Princ	e Georges			WN OR LOCAT		10d. INSIDE CITY				
	armit.		10e. STREET AND NUMBER	e Georges		pelt	sville	. ZIP CODE	12∑ YES 2 ☐ NO 10g. CITIZEN OF WHAT COUNTRY?				
	usit .	FUNERAL	3413 Dunnington F	load				20705		10g. C	USA	IAI COUNTRY?	
21215-0020	attending physician. se as the burial-transit	Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 N	YES 2 N	MED O	If yes, spe	ENDENT OF HISP ecify Cuben, Maxi 2 NO Spec	can, Puerto Rica	pecify Yes or No— n, atc.)	Black, Specify:	- American Indian, White, atc. White	
1218	al or atten for use as	TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gh	CEDENT'S USU	fone during mos		16b. Kif	ID OF BUSINESS/			
	e spi	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 4		earch	11.	t	U.S.	Dept.	of Agr	ciculture	
BALTIMORE, MARYLAND	by the hose be detach at once.		17. FATHER'S NAME (First, Middle, Last) Isaac Baker					18. MOTHER'S N Mabel R		le, Maiden Surname)		
AB	5 should) BE	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING ADD			_	City or Town, State,	Zip Code)		
Σ,		٩	Lee Cagey							Virgin		2032	
ORE	death. Page 6 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSITION 1- Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLACEA	ND DATE OF DIS	SPOSITION (Nai	me of	DATE	20c. LOCATION			
Ĭ	. Page ral dire		21. SIGNATURE OF FUNERAL SERVICE LIC		COLES		22. NAME AN	D ADDRESS OF	ACIUTYHine	s-Rinal	di Fur	, Maryland neral Home	
BALTIMORE, after death. Page 6 may be by the funeral director, page noval.	or death. Pag he funeral di al.		* Law C	1. Hol	lar	d	11800	New Ham Spring	pshire	Avenue	904		
9	within 24 hours npietely filled in t cremation, or re-		23. PARP1. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cau List only one cause of fabitu hy DUE TO 1994	n each line.							Approximata Interval Between Onest and Daeth	
	phy phy	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	AS A CONSEQ								
P.	e E	EH	resulting in death) LAST	d									
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Œ	> 0 -		DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEAT	H YES [] NO []	UNCERTA	IN B		'	YES 2 NO	
/ITAI	csician: The laving the continues of the State Dept. or Item 23	SICIAN	25. WAS CASE DEFERRED TO MEDICAL EXAMINER? 1 VES 2 \(\subseteq \text{NO} \)	HOSPITAL:			HER:	5 Pasidence					
OF	H H M	у РНУ	27. MANNED OF DEATH 1 Natural 5 Pending	28a. DATE OF INJUI (Month, Day, Yei	RY	28b. TIME OF INJURY	28c, INJU	JRY AT	-	BE HOW INJURY O	CCURED		
SION	S A S	ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJ building, atc. (URY — At horr	ne, ferm, street,			261. LOCATIO City or To	N (Street and Numb	per or Rural Rou	ite Number,	
<u> </u>	Pour Per		AA- ACRYCICA	CIAN: To the best of my ki	nowledge, dea	th occurred at	the time data	and place, and de	us to the assessa	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
	THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If I	COMPI	one) 2 MEDICAL EXAMINE	R: On the beels of examin								ind manner as stated.	
	TO THE HOSPY TO THE FUNES De filed within IMPORTANT:	H	Augusta C	Siting	m			POC. LICENSE NO	JMBER 30	321.01	ATE SIGNED (A	Month, Day, Year)	
·		5	HUGUSTO P. KOA	VIJUEZ/V	DEATH-(ITEM	27) (Type, Print)	Jaybu	mCt.	Cos	n. Mis	1 20.	748	
			31. DATE FILED (Month, Day, Year) APR 1 7 1995	32. REGISTRAR'S S	IGNATURE A	-	1		19			7	
	. L			EMILLIA EL RUSAN	EXTRAMO	17.							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



ours after death. Page 6 may be retained by the hospital or attending physician. Nun by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH Malcolm Grow USAF Medical Center Andrews AFB Maryland RECTOR RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION ੂ <u>Maryland</u> Prince George's Camp Springs FUNERAL 10e. STREET AND NUMBER 7317 Wessex Drive 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerlo Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried В 1 YES 2 ZENO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Computer Programer 17. FATHER'S NAME (First, Middle, Last) Herbert Burrell notified at Emily Jackson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Luiclle Burrell 7317 Wessex Dr., Camp Springs, MD. 20748 pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must Burial 2 ☐ Cremation 3 ☐ Removal from State

Donation 5 Ø Other (Specify) Lincoln Cemetery 4/22/95 examiner 22. NAME AND ADDRESS OF FACILITY Bruca medical 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line IMMEDIATE CAUSE (Final creim-mon. disease or condition resulting in death) BRAIN STEM HERNIATION & SEQUELA an and completer traumatic event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF): HEMORRHAGENIC CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING physician Mental Hygiene prior CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Heafth and Men PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. shows any 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN State Dept. (PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: 1 TES 2 NO N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Raeldence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT this c 1 🔯 Natural 5 Pending В 1 YES 2 NO After 1 2 Accident TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after dea IMPORTANT: If Nem 28 is nr 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER (Check only 1 📈 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the ceuse(a) and manner as stated. 2 MEDICAL EXAMINER: On 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Malcolm Grow USAF 30. NAME AND ADDRESS OF PERSON MICHAÉL P. SALATA, CAPT, USAF, MC Andrews AFB MD 20331-6600 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Davilson Randa

BURRELL

8. AGE (In yrs. last birthday)

62

IF UNDER 1 YEAR

IF UNDER 24 HRS.

5. SEX

1 M 2 - F

1. DECEDENT'S NAME (First, Middle, Last)

ALPHONSO J

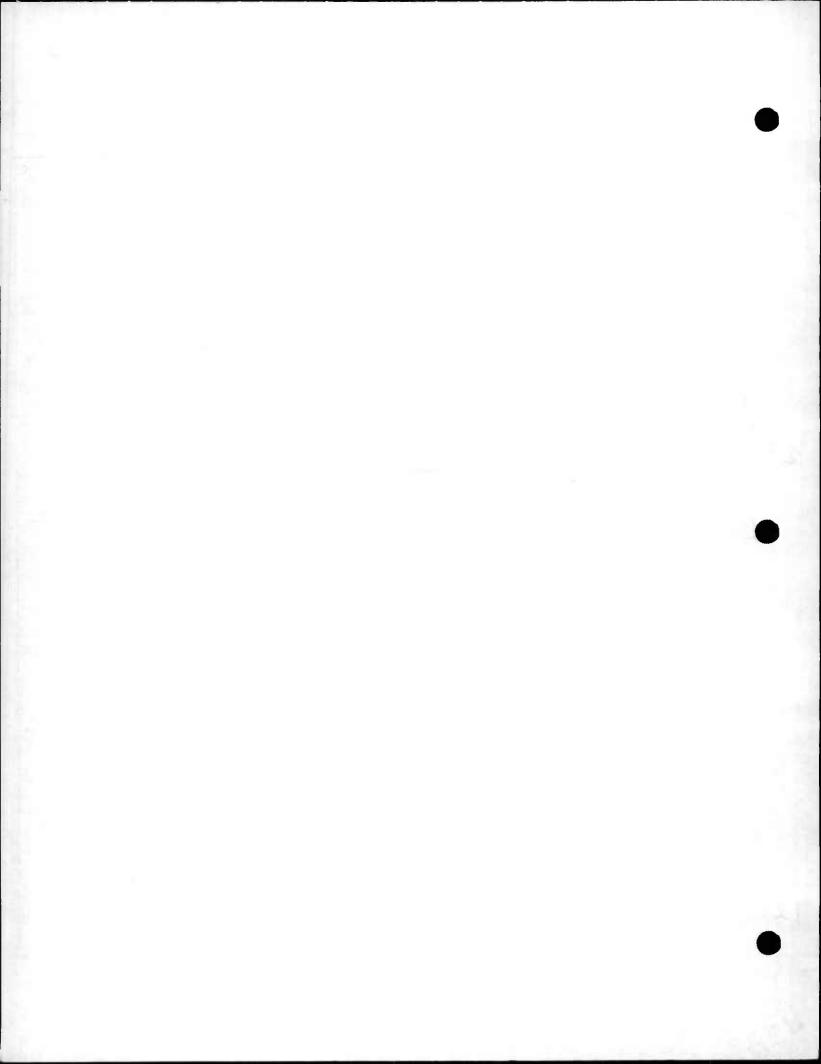
4. SOCIAL SECURITY NUMBER

579 42 8354

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REG. NO. REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH 1995 12:45 рм Apr 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign VA March 22,1933 Fredericksburg, 9c. COUNTY OF DEATH OV and Prince George's 10d. INSIDE CITY 1 X YES 2 NO CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, atc. Specify: Black 16b. KIND OF BUSINESS/INDUSTRY U.S. Government 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) 20c. LOCATION - City or Town, State DATE Brentwood, Md. McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. Interval Betw Onset and Death 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 X NO 1 | YES 2 | NO 28d. DESCRIBE HOW INJURY OCCURED 28t, LOCATION (Street and Number or Rural Route Number, City or Town, State) on and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner as stated. 29d. DATE SIGNED (Month, Day, Year) 9

Medical

APR



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho he filed within 72 hours after clearly with the Share Dear of Health and Mental Hivilene prior to burial, cremation or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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95 13684 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jack E. BOIES 18 5:50 April A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign DAYS HOURS 1XXM 2 □ F YRS. 466-03-7597 74 Nov. 27, 1920 Texas 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Perry Point VA Hospital Perryville Cecil RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Potomac 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 12224 Greenleaf Avenue 20854 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puarlo Rican, etc.)

1 ☐ YES 2 🖔 NO Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES ВУ Specify: 3 Widowed 4 Divorced World War II White 16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPL 4 Owner Janitorial Service 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) at Joel Leslie Boies Nell Freeman BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy H. Boies 12224 Greenleaf Avenue, Potomac, Maryland 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 🖟 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION/Name of cemetery, crematory or other place) APril 19, 1995
Montgomery Crematorium, Inc. 20c. LOCATION — City or Town, State n 5 🗆 Other (Specify)_ Bethesda, Maryland Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 Somon autence Darbain 23. PART I. Entar the diseases, or complications that ceused the deeth. Do not entar the mode of dying, such as cardiac or respiretory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition_ a Acute Respiratory Failure resulting in death) DUE TO (OR AS A CONSEQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSPOUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO ВУ investigation 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner es stated.

29c. LICENSE NUMBER

21902

MD # D37065

29b. SIGNATURE

BE

2

TLE OF CERTIFIER

RICHARD FREEMAN, M.D.

APR 19 1995

mai

32. REGISTRAR'S SIGNATURE

Swelson Res

VAMC PERRY POINT, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

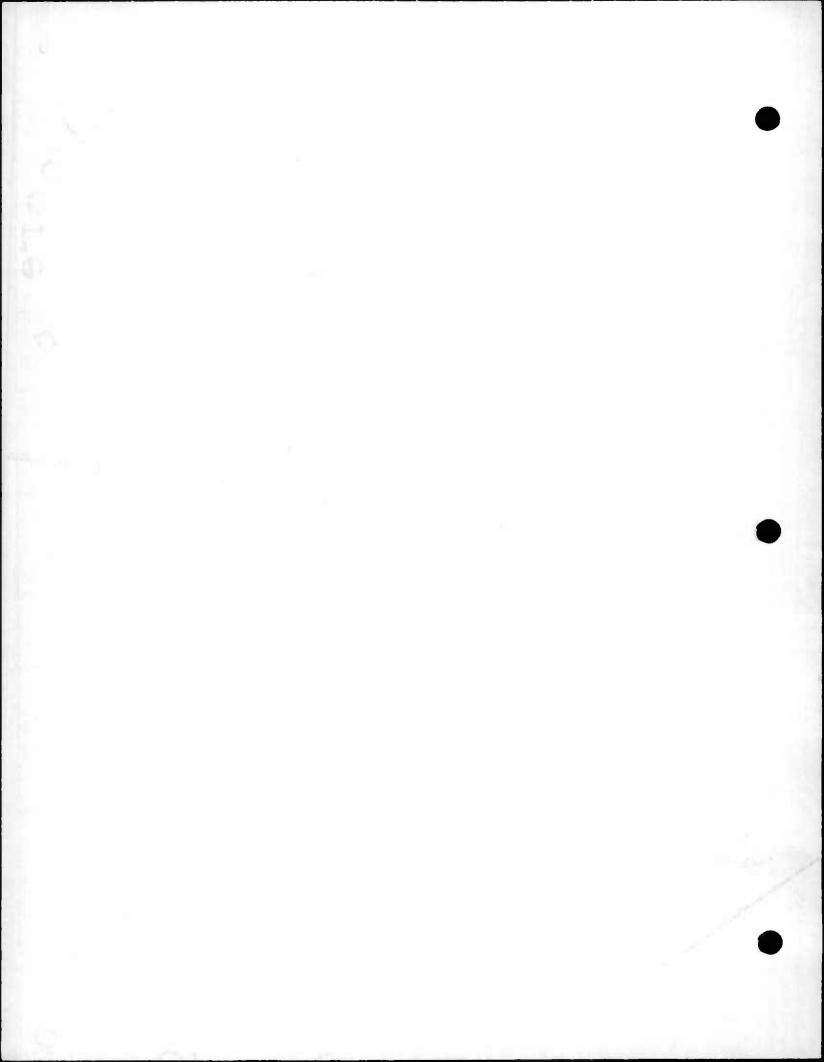
29d. DATE SIGNED (Month, Day, Year)

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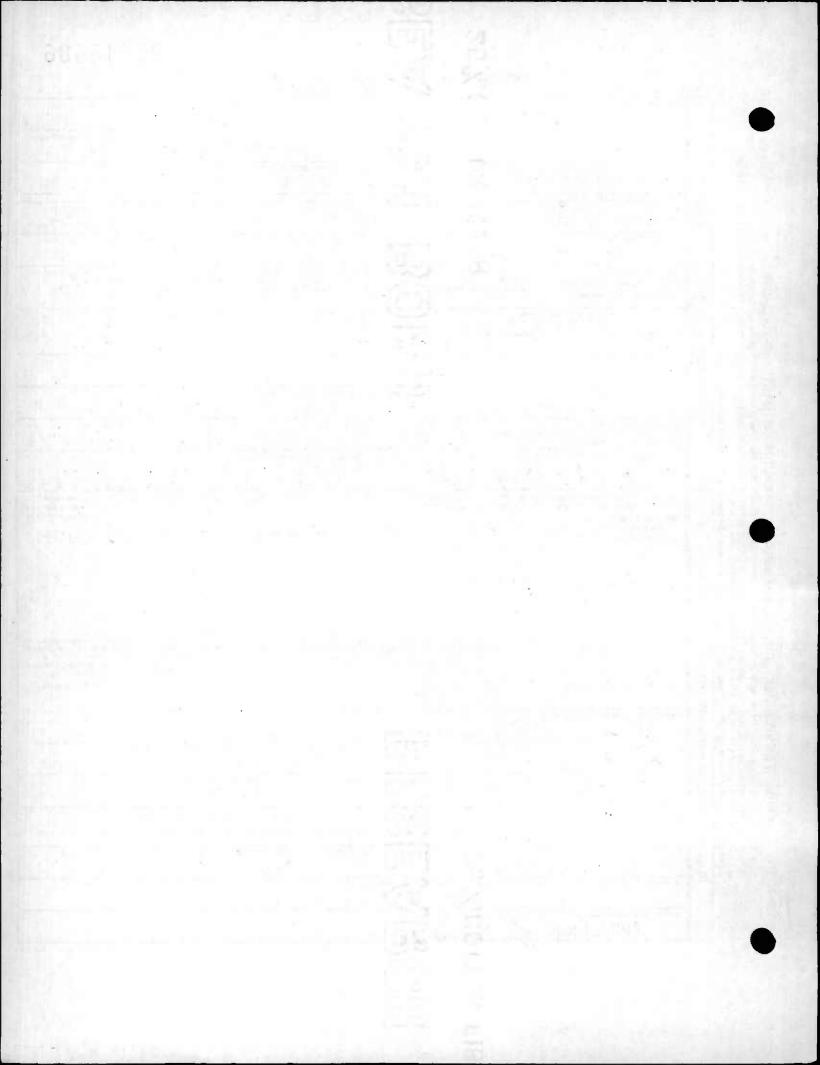
_ 3	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL	HYGIENE REG. NO.
	CEDENT'S NAME (First, Middle, Last)	Qual-land	2. DATE O	

		1. DECEDENT'S NAME (First	1 Aleksia	-		OLITTI	IOAII	_ 01	DEA	111	_	HEG. NO			
	1	MANA	Agnes	6	herh le	PVI					MONTH AOV	OF OEATH	100		2:250W M
	3	4. SOCIAL SECURITY NUME		5. SEX	B. AGE (In)	yrs. fast birthday)	IF UNDER	1 VEAD	IF UNDER	04 APP	7. DATE O		101		
	1 8			1 M 2 F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	Day, Year)		Country)	ACE (State or Foreign
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cvi	СТОВ	Suburban Ho					Bet	hes	da				Mont	gome	ery
- S	ш	10a. STATE	10b. COUNTY	,		10c. Cl	TY, TOWN (OR LOCA	ATION					L	Od. INSIDE CITY
Pages	PIE	Maryland	Mor	ntgomery			ethes								LIMITS?
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020 physician. burial-transit	FUNER	11. MARITAL STATUS	L Lake	12. WAS DECEDEN		¢ ADMED	Lan								tates
ofnysi ouria		1 Never Married 2	Married	FORCES? 1	YES :	2 XNO		If yes, s	pecify Cuba	n, Maxica	in, Puarto R	? (Specify Yes ican, atc.)	or No-	4. RACE — Black, V	- American Indian, White, atc.
2 g a	BY	3 ▼ Widowed 4 □ Divo	rced	IF YES, GIVE V	WAR OR DATE	:5		I YES	S 2 📉 NO	Specify	y:			Specify:	White
e as	B	15. DEC	EDENT'S EDU	CATION	110	a. DECEDENT'S	USUAL O	CCUPATI	ION		16b.	KIND OF BUS	SINESS/INDUS		MILLE
	Ē	(Specify only Elementary/Secondary (0	highest grade	College (1-4 or 5	.)	(Give kind of life. Do NOT u	work done ise retired.)	during m	ost of working	ng					
Spital Spital	교	12		College (1-4 of 3	·	Waitre	SS					Rest	aurant		
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, M.	icidle, Lest)						18. MOTI	HER'S NA	MF /First M	liddle, Maiden			
3 & & Z	1 111	Henry		Jones	:				1		McIn		Gurnarrier		
MAHYLAND retained by the hospil should be detached notified at once.	80	19a. INFORMANT'S NAME (7	ype/Print)	001100		19b. MAILIN	G ADDRESS	(Street					n, State, Zip C	orde)	
M/ reta 5 st		Joseph C. Be	eckley			1							, PA		2
ay be		20a. METHOD OF DISPOSITI	ION		20h Pl	ACE AND DATE				carr	DATE		PA .		
ALLIMORE, MAR death. Page 6 may be retained funeral director, page 5 should sxaminer must be notified		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)	oval from State	Cemete.	ry, crematory or e	other place)	eek	Cem	4/1	9/95	C	ettysb		
Page al dir		II SIGNATURE OF FUNERAL		ENSEE			22.	NAME A	ND ADDRES	SS OF FA	CILITY De	Vol F	ineral	Hom	ie FA
death. F tuneral		▶)(\	X	()	0.0	V.	10	Ea	st De	eer l	Park	Drive			100
	Н	1000	100	25 MY	Jun						MD 2				
3 . 0		23. PART i. Enter the di ahock, or he	seases, or c eart failure.	complications the List only one cau	t caused the	na daath. Do	not anter	the mo	oda of dyi	ing, aucl	h as cardi	ac or respi	ratory arrea	ıt,	Approximate interval Between
filled in or or or		IMMEDIATE CAUSE (Fin													Onset and Death
= 8 € =		disease or condition	→	a	Lung	NSEQUENCE C	ces	_							2 Years
rted within completely ial, cremati	1 1			DUE TO	(OR AS A CO	NSEQUENCE C	PF):		,						several
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e be execut sician and c rifor to burit traumatic	Ĕ	If any, leading to immed	diate	DUE TO	(OR AS A CC	ONSEQUENCE C	P):								
ificate be e physician one prior to	2	cause. Enter UNDERLYI CAUSE (Disease or inju		c											
requires that the death certificate een signed by the attending physical Health and Mental Hygiene pri shows any Injury, or other ti	CERTIFICATION	that initiated events resulting in death) LAS	,	DUE 10	(OR AS A CC	ONSEQUENCE C	IF):								
he death certi the attending Mental Hygie njury, or oth	買			d											
the death the attend Mental	1 1	PART II. Other significa	nt condition	a contributing to	death but	not resulting	In the un	derlyln	g cause o	lven in	Part I.	24s. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
that the the the the the the the the the th	2			rtension		Marie Constitution of the						PERFOR	MED?	AV	MILABLE PRIOR TO OMPLETION OF CAUSE
quires tha quires tha signed Health a	MEDICAL		11/1								- 1	1 YES 2	NO		F DEATH?
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has been bept. of n 23 sho	AN	DID TOBACCO U		CIBUTE TO CA		PLACE OF DEA				EKIAIN	4 🗆 📗				
OR ATTENDING PHYSICIAN: The law red DIRECTOR After this certificate has been cours after death with the State Dept. of tem 28 is marked, or item 23 sh	SICIAN:	EXAMINER?		HOSPITAL:			OTHER	R:							
SICIAN: Th certificate the State	PHYS	27. MANNER OF DEATH		1 Inpetient 2 28s. DATE OF		28b. Til			ne 5 🗆 Ra JURY AT	sidence	8 Other				
NG PHYS fter this ceath with marked		1 Natural 5 🔲 I	Pending	(Month, D.	ay, Year)		JURY	WC	ORK?		260. DESC	HIBE HOW I	IJURY OCCU!	REO	
After death	ĕ	Hecidant	nvestigation	28a PLACE O	E IN HIDY	At home, farm,			YES 2	, NO					
TTEND TOR: 4 after d			Could not be determined	building,	etc. (Specify)	At Hollie, tarill,	atient, race	ory, orne			City o	r Town, State)	nd Number or	Rural Rout	le Number,
OR ATTENDING DIRECTOR: After hours after death		29a. CERTIFIER	or is seen as								_				
A P P	P P	(Check only		CIAN: To the best of											
	COMPL	2 MEDI	CAL EXAMINE	R: On the basis of a	ramination an	nd/or investigation	on, in my o	pinion, d	death occur	ed at the	time, data a	and place, and	d dua to the c	cause(s) ar	nd manner as stated.
THE HOSPI THE FUNEF filed within	BE (296, SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	NSE NUM	ABER .		29d. DATE S	IGNED (M	onth, Day, Year)
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	70	den	sers	-wo					24	1412	7		PAP	0/15	5,1995
	ا ۲	30. NAME AND ADDRESS OF		COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type	, Print)	\	_				1 1	-	
		IPA BE		W.D. 80.	9 Ve	irs mi	11 6	269	, 120	ocku	ille.	werd	Novg	908	35/
		31. DATE FILED (Month, Day.		32. REGISTRA	R'S SIGNATU	RE									
		APR 20	1995	Jalin Dav	whorth	ardall									



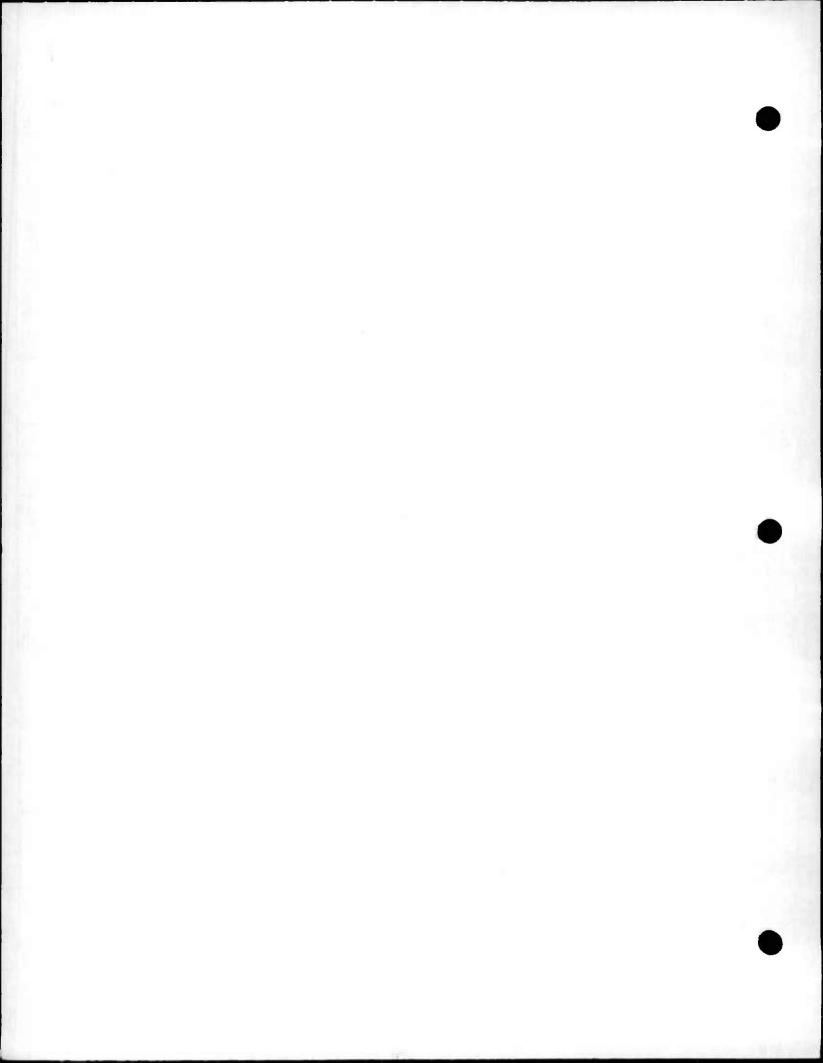
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 1				-		TOATE			, ,, ,					
	1. DECEDENT'S NAME (First	st, Middle, Last)	Mar1is	Hi1deg	gard	Borso	chei	d		2. DATE	of DEATH 11 14,	1995	YEAR	6:15 Pm
	4. SOCIAL SECURITY NUM 214-60-193		5. SEX 1 M 2 XX	6. AGE (In yrs. Ia 64	est birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (OF BIRTH Day, Year URLY 24		8. BIRTHPI Country) Germ	ACE (State or Foreign
OR	9a. FACILITY NAME (II not 4423-204 Re	omlon		2.116				SV11				9c. COUN	ITY OF DEA	
DIRECTOR	RESIDENCE OF DE 10a. STATE Maryland	10b. COUNT	v ce George	e's	10c. CITY, TOWN OR LOCATION Beltsville									0d. INSIDE CITY LIMITS? YES 2 XXNO
FUNERAL	10e. STREET AND NUMBER 4423 -204		n Street		101. ZIP CODE 20705					10g. CITIZEN OF			ZEN OF WH	
BY FUN	11. MARITAL STATUS 1XXNever Married 2 3 Widowed 4 Div		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES ZY	RMED		it yes, sp		n, Mexice	n, Puerto Ricen, atc.) Blac			14. RACE -	- American Indian, White, alc.
03	(Specify or Elementary/Secondary		College (1-4 or 5 -	-) (C	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Underwriter						16b. KIND OF BUSINESS/INDUSTRY			
COMPLET	12 17. FATHER'S NAME (First, I		+1								GEICO		ance	Co.
TO BE	Wilhelm 190. INFORMANT'S NAME			15		G ADDRESS			or Rural I		er, City or Town			
	Deborah A	TION		20b. PLACE	ANDDATE	OF DISPOS			Str	eet E	-	ille,		yland 2070
	Commettery or other place Commettery or other place													
CERTIFICATION	disease or condition resulting in death) Sequentially list cond if any, leading to immocause. Enter UNDERLY CAUSE (Disease or in) that initiated events resulting in death) LA:	ediate /ING lury ST	DUE TO DUE TO C. DUE TO d.	(OR AS A CONSE	QUENCE C	0F):								MONTHS
: MEDICAL	PART II. Other algnific	ant conditio	na contributing to	deeth but not	reculting	In the un	derlyln	g cause	given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	6	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER	₹:		- Marian Contract of the Contr	eck only and				
			28a. DATE OF (Month, D	INJURY	28b. Tis	-	28c. INJ WC	JURY AT	/		CRIBE HOW II	NJURY OCC	URED	
		Pending Investigation		28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Favor, State of										
TED BY	1 Natural 5 2 Accident	Pending Investigation Could not be determined	28e. PLACE O building,	F INJURY — At he stc. (Specify)	ome, farm,	street, fact	ory, offic	•		28f. LOCA City o	ATION (Street a or Town, State)	and Number	or Rural Roo	ute Number,
ETED BY	1 Natural 5 2 Accident 3 Sulcide 8 4 Homicide 29e. CERTIFIER (Check only	Could not be determined	SICIAN: To the bast of	my knowledge, d	eath occur	red at the t	lme, date	and place		to the cau	or Town, State)	iner se state	od,	and manner as stated.
BE COMPLETED BY	1 Matural 5 2 Accident 3 Suicide 8 4 Homicide 29e. CERTIFIER (Check only one) 2 MEI	Investigation Could not be determined COULD THE PHYSICAL EXAMIN	HICIAN: To the bast of a:	my knowledge, dixemination end/or	eath occur investigati	red at the t	lme, date	and place		to the cau	or Town, State)	ner se state	ed. o Ceuse(e) e	
E COMPLETED BY	1 Natural 5 2 Accident 3 Suicide 8 4 Homicide 29e. CERTIFIER (Check only one) 2 MEI	Investigation Could not be determined ATTIFYING PHYS DICAL EXAMIN E OF CERTIFIE OF PERSON WI	ER: On the basis of a:	my knowledge, dixemination end/or	ieath occurr Investigati	red at the toon, in my do	ime, date	and place leath occur 29c. LICI	ed at the ENSE NUR	to the cau time, data	or Town, State)	ner se state	ed. o Ceuse(e) e	and manner as stated.



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)

		MARCELLA ANN BER	LLA				3		N	onth pril	14, 1995	YEAR	8:00	N A M
		4. SOCIAL SECURITY NUMBER		AGE (In yrs. I		IF UNDER	1 YEAR	IF UNDER 2	MIN. (ATE OF BIRT	bar)	Country)	ACE (State or For	
pinous		181-22-7146 9e. FACILITY NAME (If not institution, give str	1 M 2 F	68	YRS.	an CITY	TOWN O		F OF DEATN	eb. 1			sylvani	.a
2, 3	стов	3615 Edelmar Teri						Spri				ity of DEA		
Pages 1,	ш	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION				T	Od, INSIDE CITY	
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MARYI retained by 5 should be notified at	TO B	19e. INFORMANT'S NAME (Type/Print)		1	96. MAILING	ADDRESS	(Street ar	_			or Town, State, Zip	Code)		
ay be rel page 5:	۲	Thomas Berilla									Spring,		yland 2	0906
e 6 may ector, pa		20a. METHOD OF DISPOSITION XX Burlel 2 Cremation 3 Remo	val from State	cemetery c	ematory or o	ther niscel					Oc. LOCATION — C			
		4 Donation 5 Other (Specify)	MSSE T	Gate	of H	eave			y 4	/18 S	ilver Sp	oring	, Maryl	and
ALFIN death. Pag funeral di		7/ / #	7			Hi	nes-	Rinal	di Fu	neral	Home, I	Inc.		
Institute of the tremoval.	H	3. PART i. Enter the diseases, pr co	pull	ee		111	800 :	New H	ampsh	ire A	ve., Sil	lver	Spring,	MD
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th certificate be ending physician if Hygiene prior to or other traus	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST BRAW METATIANES DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.												
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L OR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the Size them 28 is marked, or Its	ETED	3 Suicide 6 Could not be determined	26e. PLACE OF IN- building, etc.	(Specify)	ome, ferm, s	street, facto	ory, office		26f.	LOCATION (S City or Town,	Street and Number of State)	or Rural Rou	te Number,	
Z Z Z Z	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	AN: To the best of my										nd manner ee sta	nted.
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₽₽≥₹	2	30. NAME AND AGORESS OF PERSON WHO	COMPLETEO CAUSE (OF DEATH (ITE	EM 27) (Type,	Print)						1113	2///	-
18		Joseph Ke 31. DATE FILED (Month, Day, Vear) APR 21 1995 Jul	324 HEGISTRAR'S	1811		ince	e f	hil	ip b		Silvers	eri'ng	, md ac	1906
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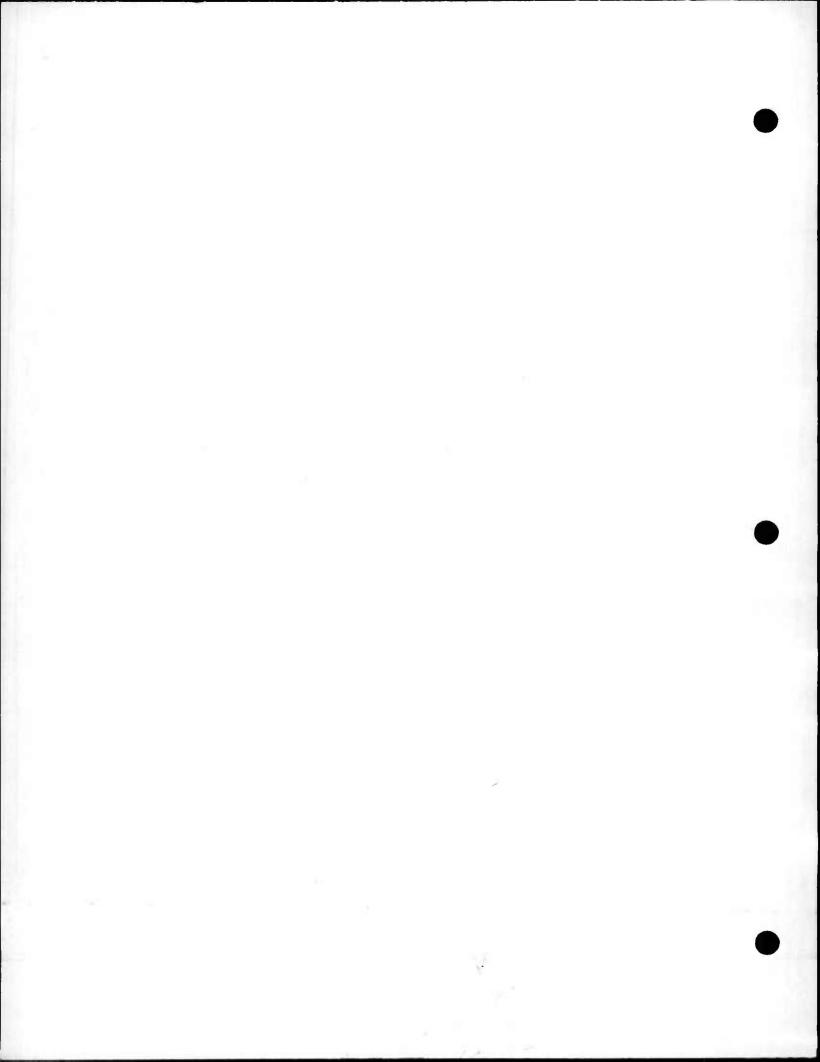
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH de Bru 1994 KICHARD ce Lewis M 4. SOCIAL SECURITY NUMBER 5. SEX S. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign HOURS 1 X M 2 | F 214-80-4006 YRS. 39 March 22,1956 Washington, DC 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Cradock Group Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery permit. 1 TYES 2 X NO FUNERAL 10a. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 1925 Cradock Street 20904 United States the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-I1 yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 K Never Married 2 Married ВҰ 1 TYES 2 X NO Specify: Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) None None 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) H Richard Lewis Bruce hours after death. Page 6 may be retained by Eleanor M. MacArthur BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Susan B. Luecker 691 Genessee Street Annapolis, Maryland 21401 Pe 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must funeral director, cemetery, cremetory or other place)
Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 enter M00202 and completely filled in by the in burial, cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Deeth the disease or condition Seizure Pisonder event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a If any, leading to immediate cause. Enter UNDERLYING 2 death certificate CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST signed by the atter Health and Mental injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? that amy 1 - YES 2 1 NO requires shows 1 TES 2 T NO been it. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M PHYSICIAN: Dept. certificate has the State Dept 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 4 Nursing Home 5 Residence (Specify) 1 | Inputient 2 | ER/Outputient 3 | DOA Group Home 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF this c 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO В After 2 Accident Investigation TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after dea IMPORTANT: If I lem 28 Is m 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER
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(Check 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 2809 april 5 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) por hw

8218 W 15 CMSIN

31. DATE FILED (Month, Day, Year)
APR 21 1995

132. ANGISTIAN'S SIGNATURE LA D'AUCLION PONDAL

20A



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

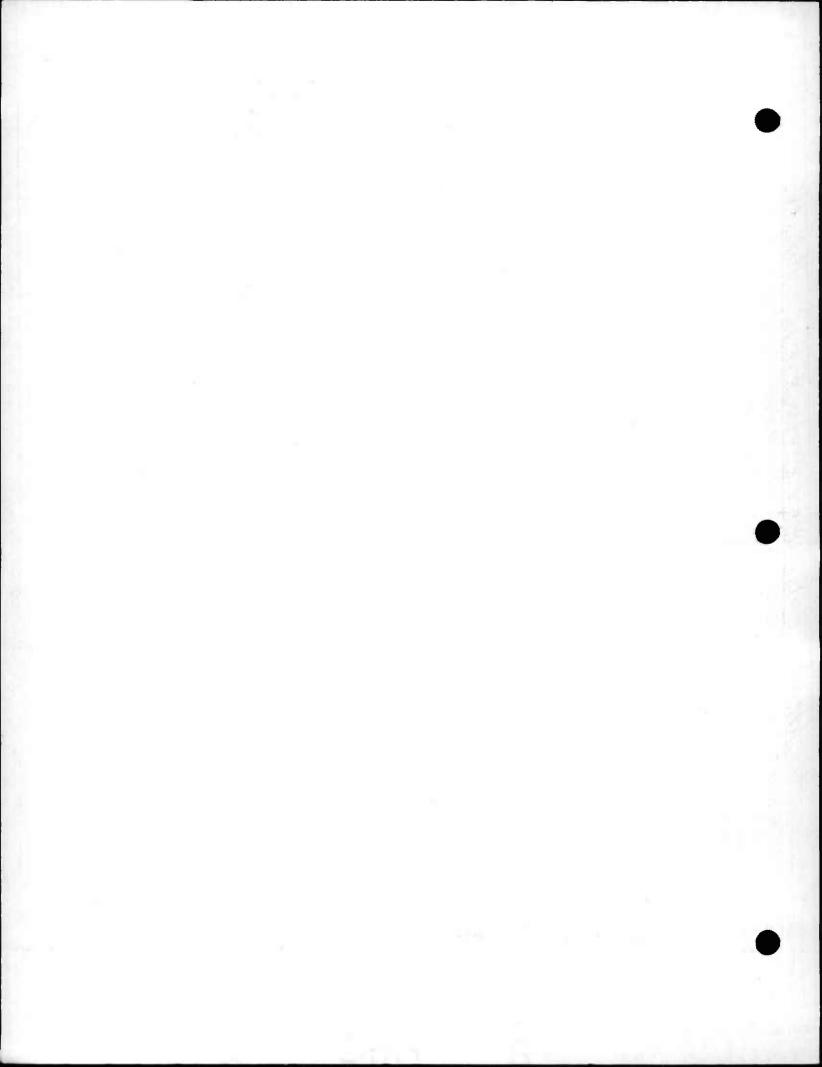
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. Ed LORINE DROCK BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICALE	: OF	DEATH		REG. NO.			
1	1. DECEDENT'S NAME (First	, Middle, Last)	M : 1 - 1 - 1	T	D			T T	MIDNI		-20-	YEAR	3. TIME OF DEATH
-	4. SOCIAL SECURITY NUMBER	acn .	Mildred 5. SEX	L.	Broc						30	95	0025 M
77.1			1 M 2 X F	6. AGE (In yrs.		IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH th, Day, Year)		S. BIRTH	IPLACE (State or Foreign ry)
H	428-28-041			74	THS.					3, 192			isiana
				2				R LOCATION OF E	DEATH			NTY OF D	EATH
DIRECTOR	Union Hosp		r Cecil (Jounty		ETI	kton		- 1-		Cec	il	
	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN C	OR LOCAT	ION					10d, INSIDE CITY
5 1	Maryland	Ceci	1		E1	kton							LIMITS?
4	10e. STREET AND NUMBER						101	ZIP CODE			10g. CITI	ZEN OF V	WHAT COUNTRY?
LONGHAL	122 East V	illage	Road					21921			U.:	S.A.	
5	11. MARITAL STATUS		12. WAS DECEDEN					ENDENT OF HISPA			or No—	14. RACE	E — American Indian, k, Whita, atc.
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	17. FATHER'S NAME (First, M	rles Sī	mith					18. MOTHER'S N					
-			III CII							ie Dod			
2	Michael R.							nd Number or Rura					0.1
-	20g. METHOD OF DISPOSIT							age Road				219	
	1X Buriel 2 Cremetic	n 3 🗆 Ramo	ovel from State	cemerery.	crematory or o	of DISPOS ther place)	SITION (Na	al Park	4 ^{DA}	ZZ I	CATION —		2200
-	4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		FNSFF	_ G11p	in Man					95 E1k			yland
	. /		1	•		"I	Tick	S Home	for F	uneral	s, P	.A.	
	Dona	ul.	2.4	elas		I	Elkt	West Sto	2192	1-5521			
i	23. PART I. Entar tha d	iseases, or c	complicatione that List only one ceu	t caused tha	death. Do i	not entar	tha mo	de of dying, su	ch as car	diec or respi	ratory arr	eat,	Approximete
	IMMEDIATE CAUSE (Fir		oy oo coo	199 011 69011 1									Interval Between Onset and Death
	disease or condition	→	. CVA	New	and to	del							71000
			DUE TO	(OR AS A CON	SEOUENCE O	F):							7dayo 15 yes 7dayo
	Sequentially list condit	ions (COP										15 yes
NILLICATION	if any, leading to imme	diate		(OR AS A CON									
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	that initieted events resulting in deeth) LAS	т	A SC		SECUENCE O	r):							6.8244.0
			d. // SC	V D.									10 ges.
	PART ii. Other significe	ont condition	s contributing to	death but no	ot resulting	in the un	deriying	ceuse given in	Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS
2007										1 YES 2	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
											1		OF DEATH?
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	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	uob===					ACE OF DEATH (C	heck only o	ne)			
5	1 TYES 2 THO		HOSPITAL:	ER/Outpetlent	3 🗆 DOA	OTHER		5 🗆 Residence	6 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH		28a. DATE OF (Month, D		26b. TIM	E OF	28c. INJ	URY AT RK?	28d. DE	SCRIBE HOW II	NJURY OCC	CURED	
		Pending Investigation		-,,,		M		ES 2 NO					
	3 Suicide 6	Could not be	26a. PLACE O	F INJURY — At	home, farm,	street, fact	ory, offici		28f. LOC	CATION (Street a or Town, State)	nd Number	or Rural F	Route Number,
	4 Homicide	datarmined							J 54.9	or rown, oraco,			
	29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the beat of	my knowledge,	death occurr	ed at the ti	lme, data	and place, and du	a to the ca	use(a) and man	ner aa stat	ed.	
5) and manner as stated.
3	29b. SIGNATURE AND TITLE							29c. LICENSE NL					(Month, Day, Year)
4	Jui Ehi	L Has	UMD					D0482			▶ ∠	124	145
2	30. NAME AND ADDRESS OF			SE OF DEATH (TEM 27) (Type	, Print)		× - 102			- 7	1	117
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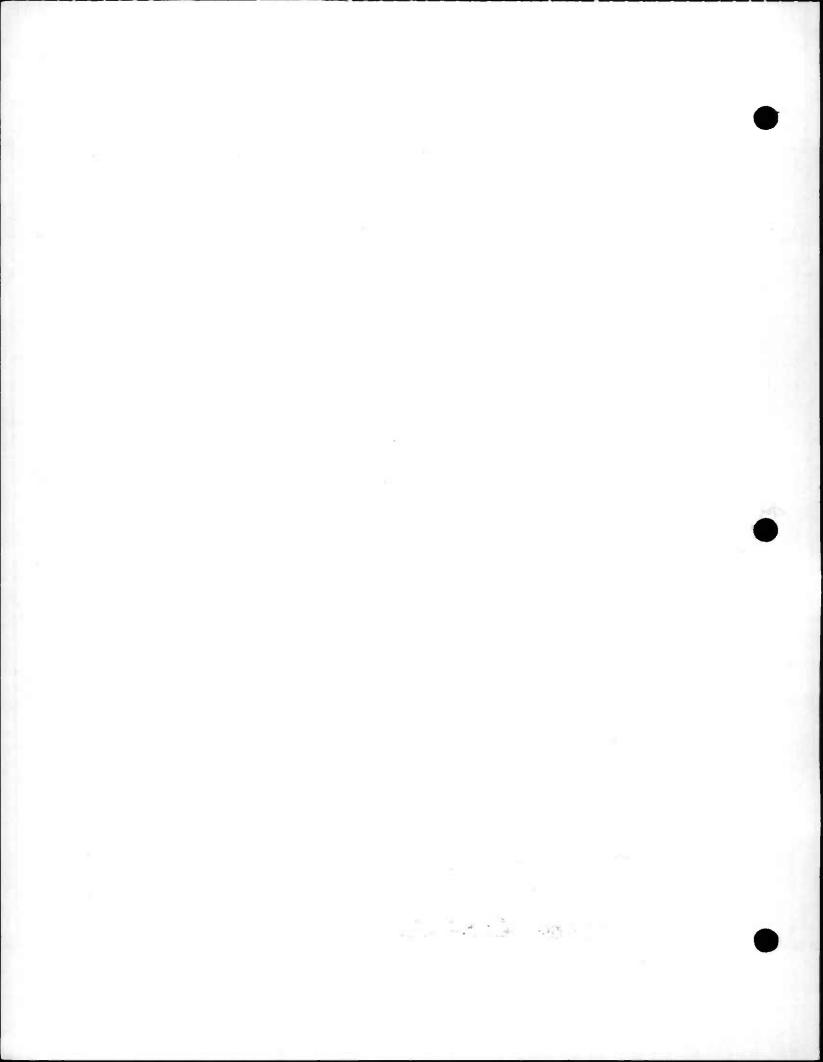
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permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH AEG NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Martha Elizabeth BLUME 1995 10:12 A M April 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 214-09-5608 1 M 2 X F 89 Aug. 15,1905 Maryland Sa. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Williamsport Homewood Retirement Center Washington 10a. STATE 10b. COURTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Williamsport 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 16505 Virginia Avenue 21795 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Mexican, Puerio Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, While, alc. 1 Never Married 2 Married Specify: White B 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Homemaker Personal Residence 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles F. Blickenstaff Lizzie M. Palmer notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joseph M. Blickenstaff 308 Avon Road, Hagerstown, Maryland 21740 e 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 N Buriel 2 Cremation 3 Ramoval Irom Stale
4 Donalion 5 Other (Specify) Rest Haven Cemetery 4/25/95 Hagerstown, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 21742 Douglas A. Fiery A Day 1331 Eastern Blvd. North, Hagerstown, MD reunton medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final and Death the disease or condition resulting in death) DONTO (OR AS A CONSEQUENCE OF) event, Emoria traumatic CERTIFICATION Sequentially list conditions, O IOR AS A CONSEQUENCE OF if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE DF DEATH? 1 TYES 2 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 1 PHYSICIAN: **ÚNCERTAIN** □ 23 25. WAS CASE REFERBED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL NO 1 YES 2 Inpetient 2 - ER/Outpetient 3 -DOA Nursing Homa 5 - Residence 6 - Other (Specify) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death was BY 2 Accident
3 Sutcide Investigation 28s. PLACE OF INJURY — Al home, lerm, atreet, lectory, office building. etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 8 Could not be 28 4 Homtclde determined Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If II of axamination end/or investigation, in my opinion, death occured at the time, date and piecs, end due to the cause(s) end manner as stated. 8 **FILL LICENSE NUMBER** 29d. DATE SIGNED (Mc 1 Con

AUSE OF DEATH (ITEM 27) (Type, Pri



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fourth of the fourth of the hospital or attending physician.	IN THE FUNE FAIL DIRECTOR. AND THE CHARLES SHEET IN SECURCIAL IN SECURCIAL IN SECURCIAL AND SHEET OF THE FUNE FAIL DIRECTOR. PAGE 3 SHOWING THE FUNE FAIL DIRECTOR. AND THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR. AND THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE FUNE FAIL DIRECTOR OF THE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buinal, cremation, or removal.	IMPORTANT: If them 28 is marked, or liem 23 shows any injury or other traumatic event, the medical examiner must be notified at once.
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1. DECEDENT'S NAME (Firs	t, Middle, Last)		2					2. DATE OF	DEATH		YEAR	3. TIME OF DEATH
Mary	Va	ne	120h	ma	n			april	16	19	95	2:09
4. SOCIAL SECURITY NUM 214-09-8191		5. SEX	6. AGE (In yrs		MONTHS DAY		MIN.	7. BATE OF (Month, De	BIRTH ly, Year)	′ -I	Countr	IPLACE (State or Foreign
		1 M 2 M F	/	8 YRS.					5, 191	6	Mary	iland
9m. FACILITY NAME (# not #			7			WN OR LOCATI		EATH	94		NTY OF D	
	Shington County Hospital					Hagerstown						igton
10a. STATE	10b. COUNTY									10d. INSIDE CITY		
Maryland	Wash	ington			Hagers	town						LIMITS? 1 YES 2 M NO
104. STREET AND NUMBER						10f. ZIP COD			10	g. CITI	ZEN OF Y	VHAT COUNTRY?
17321 Diane	Drive					217	40			U	SA	
11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA									GIN? (Specify Yee or No- no Rican, etc.) 14. RACE — American Black, White, etc. Specify: White			c, White, etc.
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Elementary/Secondary (College (1-4 or 5 +	•)	We. Do NOT us	se retired.)		raf		-7. 7			
12		0		teac	her's				chool			
17. FATHER'S NAME (First, A Walter Halb	ack					J	enni	ME (First, Midd e Smit	h			
19a. INFORMANT'S NAME (Kenneth Har	bauah			196. MAILING	Diane	eet and Number	or Rural F	Route Number, (City or Town, St	tate, Zip	Code)	1740
20a. METHOD OF DISPOSIT	TION		20b. PLA	CEANDDATE	OF DISPOSITION	N/Name of	nage	DATE		_		
1 Buriel 2. Crematic 4 Donation 5 Other	TION on 3 - Remo	-0 6-2003	20b. PLA carretary. Hage	CEANDDATE	of Disposition of the place of the Cremo	atory E AND ADDRE	4-: ss of fai UNER	DATE 18-95 CILITY PAL HOM	20c. LOCATI Hage1	ion —	Own,	Mary land
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1 Guriel 2/JC Crematide 4 Donation 5 Other 21. SIGNATURE OF FUH 223. PART I. Enter the dishock, or h IMMEDIATE CAUSE (Firdisease or condition resulting in death) Sequentially list condition from the cause. Enter UNDERLY CAUSE (Disease or Injuit that initiated events resulting in death) LAS	TION 3 Remore (Specify) BERVICE LICE BERVI	Dompilications the List only one ceu	cemetary, Hage Hage Report of the Se on each I COR AS A CON COR COR AS A CON COR AS	CEANDDATE. Cremetary or of PS town CPS town Ideeth, Do a ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF ISEOUENCE OF	of Disposition when place in Crema MINI 415 not enter the	Alphaneol atory E AND ADDRE NICH F E. Wi mode of dyl	4- ss of FAM UNER 1son lng, suci	DATE 18-95 CILITY PAL HOM Blvd. h as cerdlec	Hages Hages Hages Hages	rstory arr	City or To OWN, OWN, ost,	Mary Land Mary Land Ma. 2174(Approximate Interval Between Onset and Decomposition of Company Compa
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		IENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	Frankl.	n B	oyd		4-16-19	995	YEAR	ME OF DEATH
		™ 2 □ F	yrs. lest birthdey) 66 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF OEA	7. DATE OF BIRTH (Month, Day, Year) 10-6-192	28	Country)	land
STOR	Washington Coun		al		stown			shing	ton
- DIRECTOR		ngton		, town or locat illiams	sport				INSIDE CITY LIMITS? YES XIX NO
FUNERAL	16822 Tammany M				21795		U.	S.A.	OUNTRY?
Z R	1 Never Married 2 Married 3 Wildowed 4 Divorced		2 NO	If yes, sp	CENDENT OF HISPANI ecify Cuban, Maxican, 2 ND Specify:	C ORIGIN? (Specify Ye , Puarto Rican, atc.)	a or No—	4. RACE — An Black, White Specify: Whit	
PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of s	usual occupation work done during mo	at at marking	Genera			Corn
E COMPL	17. FATHER'S NAME (First, Middle, Last) Frank Nish Boyd		CCIIII	21.011		E (First, Middle, Meider T. Seil	Surname)	VOLB	0010.
TO B	Bernice Elizabe	th Boyd	19b. MAILING 16822	ADDRESS (Street of Pamma)	and Number or Rural Ro any Mano	r Rd. Wi	vn, State, Zip C Lllia	mspor	t ₂₁ 795
	20r METHDD DF DISPOSITION 1-0 Burlal 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. SAGNATURE OF PRINCE LICEN	I from State cemete	ROSE T		4-19-	1995 C	Lear	ty or Town, St. Sprin	g, MD
	Larg H.	Oclou-	_	2 Thomas	Box 31	Meral Ho O Clear	ome, Spri	Inc. ng, M	D 2172
	23. PART I. Enter the diseases, or con ahock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	Am LL	he death. Do r h ilne. According ONSEDUENCE OF	ot anter the mo		aa cardlac or reap	Iratory arre	ŀ	Approximate interval Batween Onset and Daath
ERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in daath) LAST	Dive TO (DR AS A C SNO LEVE OUE TO (DR AS A C ĈE	ONGOUENCE DE LE DISEDUENCE DE LE LE LE LE LE LE LE LE LE LE LE LE LE	infres	afic le	inge Co	a/s	quan	iers
MEDICAL CE	PART II. Other algolificant conditions of	contributing to death but	not resulting			1/	AUTOPSY RMED?	24b. WERE AWARJ COMP OF DE	AUTOPSY FINDINGS AIRLE PRIOR TO LILTION OF GAUSE ATHT YES 2 1 NO
PHYSICIAN: I	DID TOBACCO USE CO	ONTRIBUTE TO C		26. PL	YES NO	k only one)			
ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26s. DATE OF INJUSTY (Month, Day, Year)	38b. TiM	E OF 28c INJ		28d. DESCRIBE HOW	NUURY DCCU	REO	
ETED B	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF BUILTRY — building, etc. (Specify)	At home, farm, s	treet, factory, offic		DBF. LOCATION (Street City or Town, State	and Number or	Flural Floure No.	imbec
COMPLE		To the best of my knowled on the bests of examination a							nanner as stated.
BE	290. DIGMATURE AND TITLE OF CERTIFIED	A	- M.D)_	296. LICENSE NUMB	131	29d. DATE 5	HIVE HOUR	Day Hears
TO	30, NAME AND ADDRESS OF PERSON WHO C	CHRISE OF DEATH		Philip (- 0 (WASN	· loi	wy	1 Ho	88.



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DIVISION OF VITAL BECORDS, P.O. BOX 68760.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		IENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last Mary Magdal					-		3. TIME OF DEATN	
	4. SOCIAL SECURITY NUMBER 213-40-6820	5. SEX 8. AGE ((In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Mogrin, Ob., 1681)	8.1	BIRTNPLACE (State or Foreign Country) ennsylvania	
TOR	9a. FACILITY NAME (# not institution, give Washington Col		al		or location of DEA rstown,	XTH .	9c. COUNTY Wasl	of DEATN hington	
DIRECTOR	10a. STATE 10b. COUN	nington		Clear Spring,				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	12657 Big Po		10	U . S . A .					
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D	N U.S. ARMED 2 NO ATES	II yes, sp	CENDENT OF NISPANII Decity Cuban, Maxican, S 2 NO Specify:	C ORIGIN? (Specify Ye , Puarto Rican, atc.)		RACE — American Indian, Black, Whita, etc. Specify: White	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)		18a. DECEDENT'S I (Give kind of w life. Do NOT use Homem	ork done during mo n retired.)	ON ost of working	16b. KIND OF BU		Residence	
BE COM	17. FATNER'S NAME (First, Middle, Last) George Mc Cu	llough			Harri	ett Bish	op		
10	19a. INFORMANT'S NAME (Type/Print) Linda Wigfie		1264	5 Big	Pool Rd	. Clear	Sprin	g, MD 21722	
	20a. METNOD OF DISPOSITION 1. Burial 2 Cremation 3 Rai 4 Donation 5 Other (Specify)	moval from State	PLACE AND DATE O	en Cen	etery 4		Hager	stown, MD	
	1/1/95/1	MIVIN		P.O.	Box 310	O Clear	Sprin	g, MD 21722	
	23. PART i. Entar the diseases, or ehock or heert fellure iMMEDIATE CAUSE (Finel disease or condition resulting in daeth)	a. Resident on the cause on each of the cause on each of the cause on each of the cause on each of the cause	ach line.				iratory errest,	Approximata interval Between Onset and Deetl	
CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	marla d	Lecius		year	
MEDICAL (PART II. Other eignificent condition	one contributing to death b	ut not resulting in	the underlyin	g ceuee given in P	art i. 24s. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
AN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YES						
PHYSICI	1 TYES 2 TO NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Ouip 28e. DATE OF INJURY (Month, Day, Year)		OF 28c, INJ	ne 5 Residence 8	Other (Specify) 28d. DESCRIBE HOW	NJURY OCCURE	EO	
ED BY	1 Anatural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF INJURY	M 1 VES 2 NO At home, larm, streel, lactory, office 28f. LOCATION (S			281. LOCATION (Street City or Town, State)	(Street and Number or Rural Route Number, , State)		
COMPLET		SICIAN: To the best of my knowl						use(s) and manner as stated.	
O BE C	29b. SIGNATURE AND TITLE OF CERTIFI	E)			29c. LICENSE NUMB	ER	29d. DATE SIG	GNED (Month, Day, Year)	
TO BE COM	BARRY A. CORRE	NO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print) Print)	HAGEN.	TOWN,	MZ	21742	

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8 aragre-Jennie 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 M 2 X I 217-20-5611 68 YRS Pages 1, 2, 3 should 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Union Memorial Hospital Baltimore RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Harford Havre de Grace permit 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 140 Deaver Street funeral director, page 5 should be detached for use as the burial-transit 21078 BALTIMORE, MARYLAND 21215-0020 fours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ★ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Pusrto Rican, stc.) 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 0 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highes College (1-4 or 5+) COMPL 9 Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 7 John Leonard Owens BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Ronald P. Baker, Sr. 312 Lafayette St., Havre de Grace, MD 21078 must be 20s. METHOD OF DISPOSITION
1 ABurlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Angel Hill Cemetery 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Havre de Grace, MD this certificate has been signed by the attending physician and completely filled in by the with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. the medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel diseese or condition 998 resulting in deeth) other traumatic event, THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760, abetes CERTIFICATION Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST ö PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IS PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 - YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 ☐ Residence 8 ☐ Other (Specify) 6 28s. DATE OF INJURY 27. MANNER OF OEATH 28b. TIME OF 28c. INJURY AT WORK? is marked, 1 Natural м DIRECTOR: After the hours after death was 1 YES 2 NO В 2 Accident Investigation 28s. PLACE OF INJURY — At homs, term, streat, tectory, office building, stc. (Specify) 3 Suicide COMPLETED 8 Could not be detarmined 28 4 Homicide G FUNERAL DIV. Within 72 hours. 29a, CERTIFIER 1 A CERTIFYING PHYSICIAN: To this beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: It MEDICAL EXAMINER: On the basia of sxamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER. 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

2

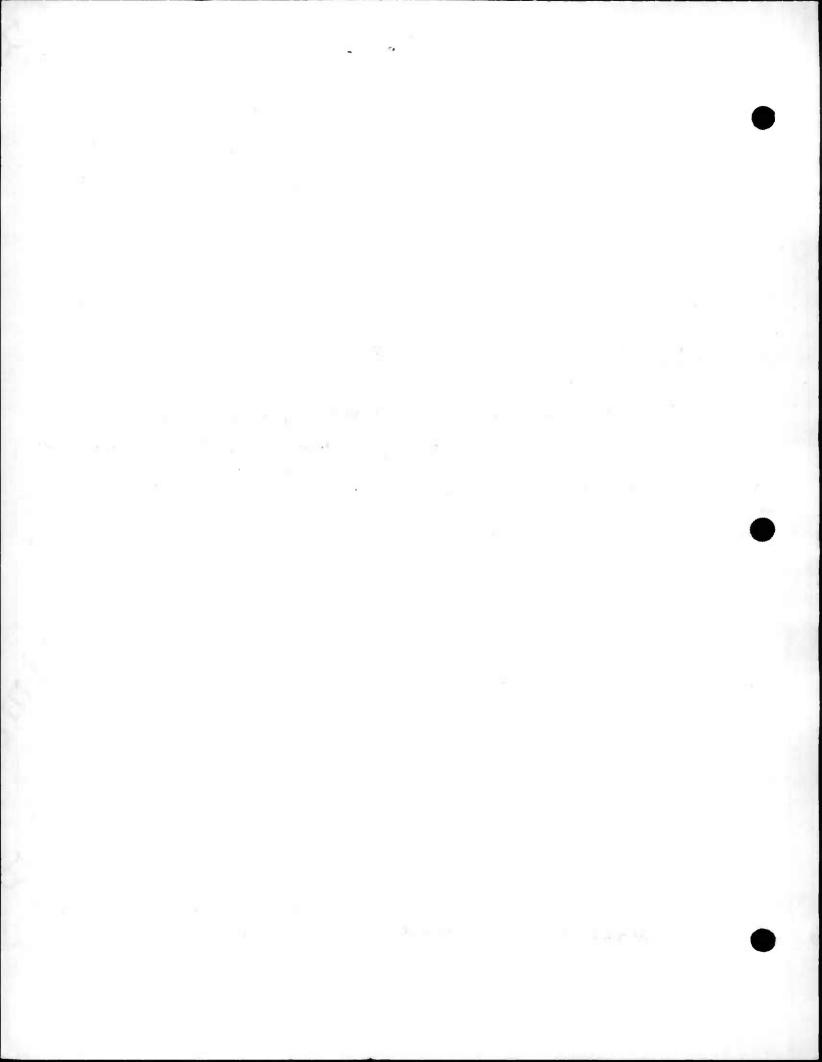
Brian

31. DATE FILED (Month, Day, Year)

APR 2 1 1995

1. DECEDENT'S NAME (First, Middle, Last)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF OEATH 3. TIME OF DEATH 7:15 7. DATE OF BIRTH 08-02-1926 MD 9c. COUNTY OF DEATH 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE --- American Indian, Black, Whits, stc. Specify: White 16b, KIND OF BUSINESS/INDUSTRY Home 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Orr DATE 20c. LOCATION — City or Town, State 4/24 Havre de Grace. Mitchell-Smith Funeral Home, P.A. 21078-3197 Approximate Intervel Betwe **Onset and Death** 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. OATE SIGNEO (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT ITTEM 28 MARKED OF IREM 23 SHOWS ANY INCIDENTIANT PROPERTY TO TRANSPORT THE BACKBAN OF SHORE
The state of the s

296. SIGNATURE AND TITLE OF CERTIFIER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

BE

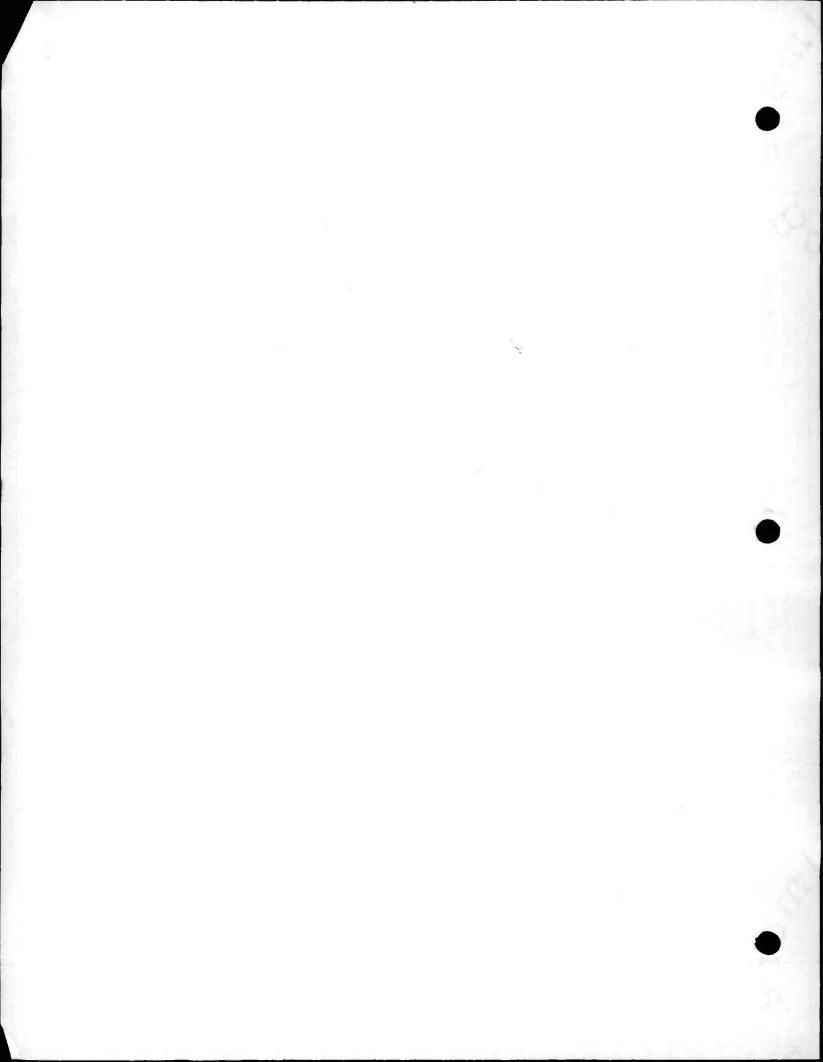
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOSEPH BISHARA APRIL 15, 1995 18:06 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Dey, Year) April 19 1926 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign M 2 F 113-14-5308 68 New York 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY 0 MD Anne Arundel Annapolis YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1021 Boucher Avenue 21403 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 1 TES 2 NO Specify. 3 Widowed 4 Divorced White 1944 - 1946 16a, DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) 12 Salesman Food Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Spero Bishara BE Selma Aswad 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alfred Bishara 146 Spa Drive Annapolis, Maryland 21403 20a, METHOD OF DISPOSITION
1 Deurlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Hillcrest Cemetery 4/19/95 4 Donetion 5 Other (Specify) Annapolis, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ohn M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complications that caused the death so not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fellure. List only one ceuse on each line. intervel Batween IMMEDIATE CAUSE (Finel Onset and Death disesse or condition entricular tachycard is resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? 1 YES 2 NO 1 TYES 2 PNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdenca 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO В 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Coutd not be determined COMPLETED 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and place, and due to the cause(s) and manner as stated.

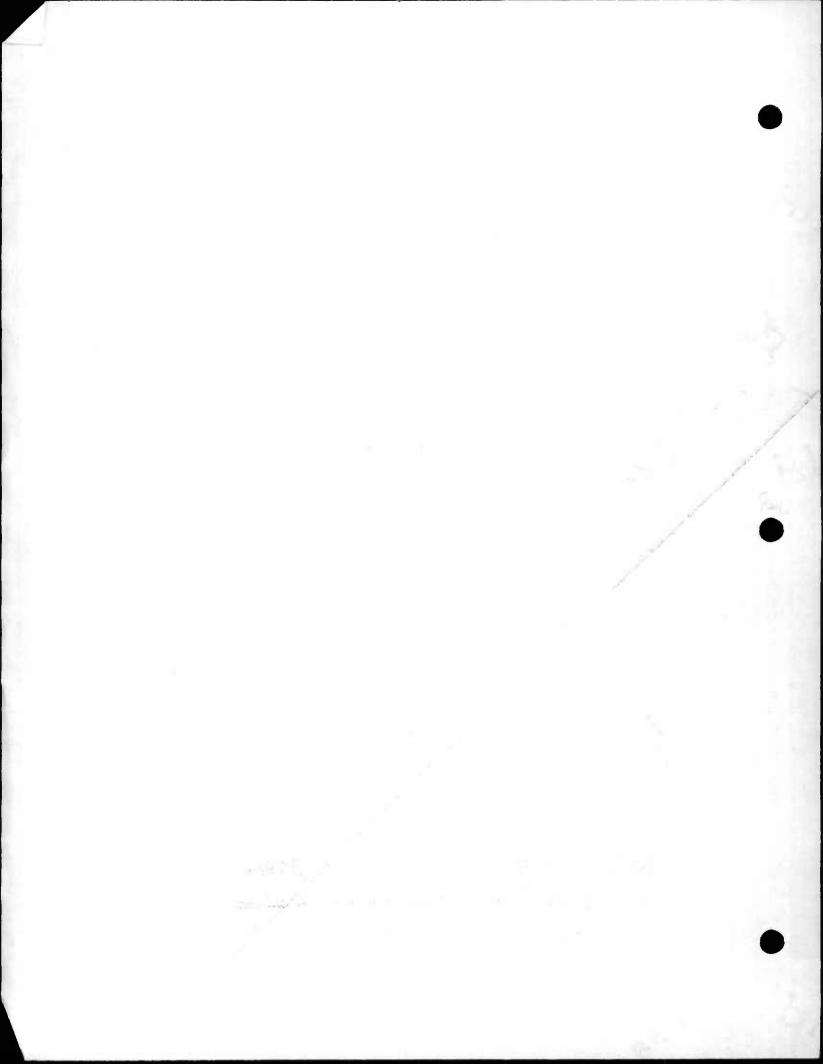
29c. LICENSE NUMBER

29d. DATE SIGNEO (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020 hours after

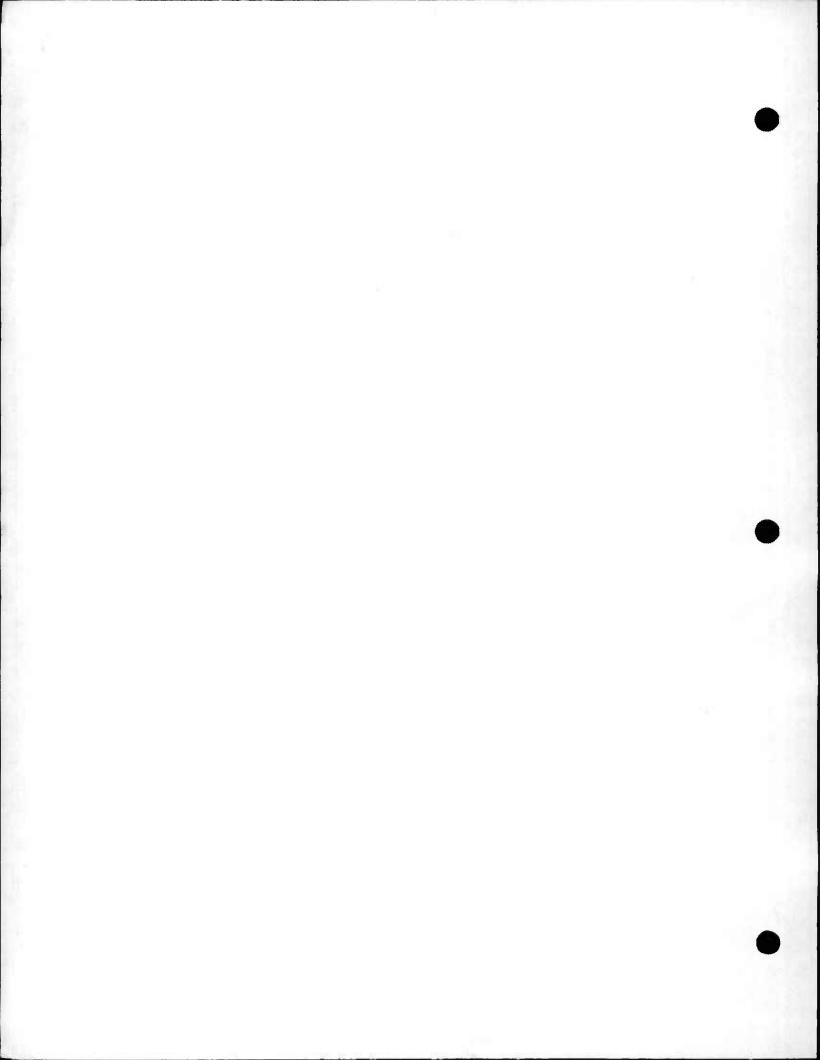
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, MIC 2. DATE OF DEATH 3. TIME OF DEATH APRIL 15 1995 7:35 am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Yea DEC. 11 S. SEX 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAVE 212-34-0108 1 ☐ M 2 😿 F 60 MARYLAND 1934 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND. ANNE ARUNDEL HARWOOD permit. YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 4336 MUDDY CREEK ROAD 20776 USA death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yas or No-It yes, specify Cuban, Maxican, Puarto Rican, stc.) 1 — YES 2 X NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION sectly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe ost of working Elementary/Secondary (0-12) College (1-4 or 5+) 12th NURSE CROWNSVILLE ST. HOSPITAL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) T BE THOMAS DORSEY MARY ROSS notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES P. BLAKE 4336 MUDDY CREEK RD. HARWOOD, MD. 20776 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must 1 S Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MOSES CEMETERY 4/20/95 DRURY. MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. Leve B21 WEST ST. ANNAPOLIS, MD. 21401 and completely filled in by the or burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate interval Between Onset and Death **IMMEDIATE CAUSE (Finel** the SCV disease or condition resulting in death) month event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): 12/1 traumatic CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician are prior to the p if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? any 1 YES 2 NO shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has by Dept. PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The Jaw 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) certificate his EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA ng Home 5 ☐ Residence 5 ☐ Other (Specify) 27. NAMER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 1 YES 2 NO BY After 2 Acciden Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28 is 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 6 Could not be 4 Nomicide determined If item 29a. CERTIFIER (Check only one) ERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and dua to the cause(s) and manner as atteted. FUNERAL E TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER
2 2 8 6 40 BE 29d. DATE SIGNED (Month, Day, Year) 2 ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Trpo, Print) 556 31. DATE FILED (Month Studen Randall



DHMH-18 Rev 1/89

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WILLIAM 40R 0648AM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (in yrs. lest birthday, 7. DATE OF BIRTH (Month, Day, Year IF UNDER I YEAR a. BIRTHPLACE (State or Foreign 217-28-6861 1 XM 2 F 63 Jan. 6,1932 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg permit. 1 YES 2 KNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? hours after death. Page 6 may be retained by the hospital or attending physician. Befin by the funeral director, page 5 should be detached for use as the burial-transit to 12224 Quince Valley Dr. 20878 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexicen, Puerto Rican, etc.) RACE — American Indian, Brack, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married Fyes, ove war or pares
Korean War 1 YES 2 NO Specify: BY Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs Machinist 2 Auto Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Robert L. Campbell Elsie Berry BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878
12224 Quince Valley Dr., Gaithersburg, MD 2 Nannie P. Campbell (Wife) 9 20a METHOD OF DISPOSITION
21.2 Burlel 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must PTeasanthVTew Cem. 4/18 Rockville, MD examiner 22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. t by the fi ROCKVILLE, MD 20850 I. Enter the classes, or complications that cause on each or heart failure. List only one cause on each medical completely filled in by ins that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, Approximata Interval Bety IMMEDIATE CAUSE (How Onset and Death the disease or condition Myo cardial resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF) HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed the attending physician and com i Mental Hygiene prior to burial, CERTIFICATION pronory uears Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Health and N No 11 itus 23 shows any 1 TYES 2 NO OF DEATH? 1 TYES 2 NO t of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\overline{\ has be 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item s certificate h OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA ng Home 5 - Reeldence 6 - Other (Specify) the 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c is marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Accident DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO BY 28e. PLACE OF INJURY — Al home, lerm, street, lectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTL DE filed within 72 hours at IMPORTANT: If Item 2! 29e. CERTIFIER 1 Z CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee stated. 2 MEDICAL EXAMINER investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and menner as stated, 296. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month. Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, FRIESTA WAYNE 10al ock ville 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

requires that the death certificate be executed within OR ATTENDING PHYSICIAN: The law

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1. DECEDENT'S NAME (First, Middle, Last)

& Server MD

J.BERGER MD

31. DATE FILED (Month, Day, Year)

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Davidson Randall

7720 WISCONSIN AVE

BeThesda

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1 M 2 F

LUISA

4. SOCIAL SECURITY NUMBER

163-26-1688

78 hours after death, Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF OEATH Southern Maryland Hospital DIRECTOR Clinton RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Prince Georges Upper Marlboro FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 7107 Antock Place 20735 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2XXNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Maxican, Puarto Rican, etc.)
 T YES 2 NO Specify: 1 Never Married 2 Married B 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) COMPLE Elementary/Secondary (0-12) College (1-4 or 5+) 5 0 Homemaker 17. FATHER'S NAME (First, Middle, Last) Antonino Prestandrea notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Ione Greenawalt be 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 X Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify) Gate of Heaven traumatic event, the medical examiner 22. NAME AND ADDRESS OF FACILITY PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiretory arrest, shock or heart failure. List only one cause on each line. in and completely filled in by the to burial, cremation, or removal. **IMMEDIATE CAUSE (Final** disease or condition resulting in death) CARDIO-PULMONARY APREST DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): CALION Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to Subdural Hematoma CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF) CERTIF that initiated evanta resulting in death) LAST injury. PART il. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL ATLUROSCHEROSIS. Dishetes mellitus shows any t, of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: DIRECTOR: After this certificate hours after death with the State OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF marked, 1 X Natural 5 Pending Investigation 1 YES 2 NO ВY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 8 Could not be 28 4 Homicide determined item 29a. CERTIFIER

1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE FUNERAL OF THE FUNERAL DE FILED WITHIN 72 hr IMPORTANT: If III 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR | IF UNDER 24 HRS.

CHIED

6. AGE (In yrs. lest birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF DEATH 3. TIME OF DEATH 1995 APRIL 2/10 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Form) Oct. 4, Pennsylvania 9c. COUNTY OF DEATH PRINCE GEORGES 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. SpecMy: White 16b. KIND OF BUSINESS/INDUSTRY Home 18. MOTHER'S NAME (First, Middle, Maiden Surname) Concetta Briguglio 15944 Indian Hills Terrace, Rockville, MD 20855 DATE 20c. LOCATION - City or Town, State 4/17/95 Silver Spring, MD Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD Approximata interval Batween Onset and Daath 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 T NO OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 025925

3. TIME OF DEATN

REG NO

2. DATE OF DEATN

FOR STATE REGISTRAR

James

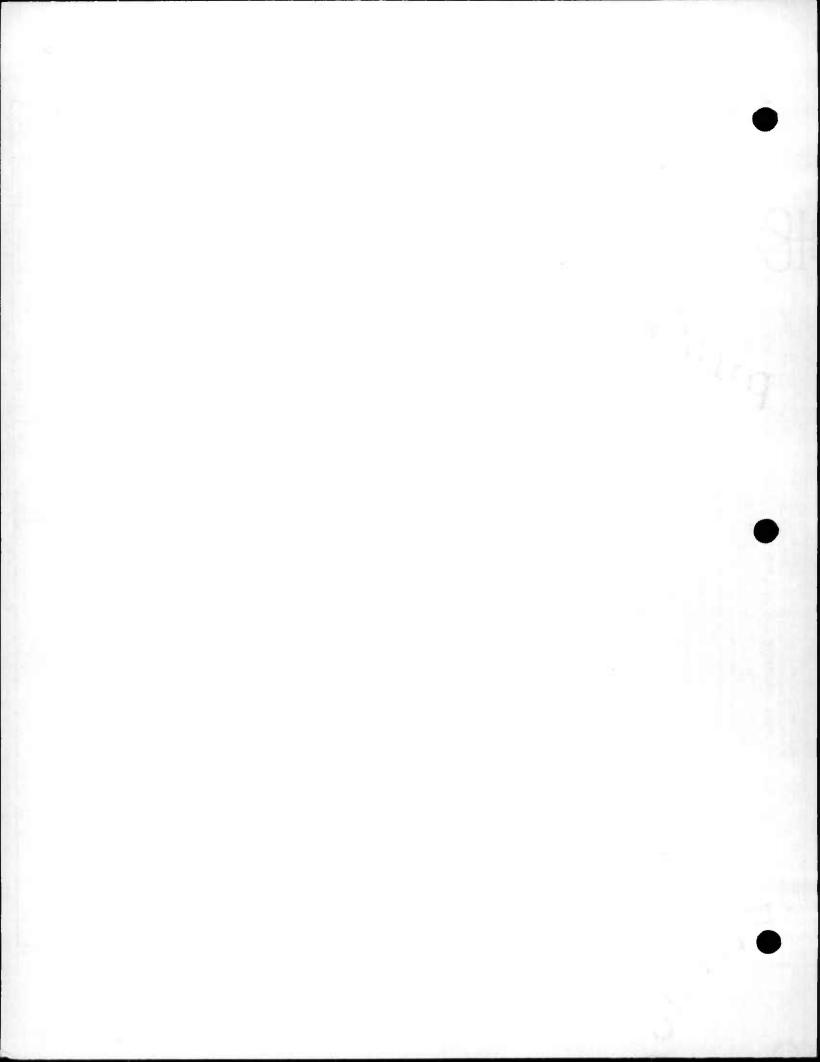
1. DECEOENT'S NAME (First, Middle, Last)

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Crawford, Jr. 10 1995 April 11:30 P M 4. SOCIAL SECURITY NUMBER S SEY 7. DATE OF BIRTN (Month, Day, Year) Aug. 25, 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign 577-03-4812 1 X M 2 | F DAYS HOURS 84 Washington, D.C 1910 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital 01ney Montgomery RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring permit. 1 - YES 2 - NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15101 Interlachen Drive, Apt. 816 detached for use as the burial-transit 20906 USA hours after death. Page 6 may be retained by the hospital or attending physician 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 K Merried IF YES, GIVE WAR OR DATES ВY 3 Widowed 4 Divorced WW II White COMPLETED 15. OECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY /Sn most of working (Give kind of work done life. Do NOT use retired.) nentary/Secondary (0-12) College (1-4 or 5+) Assistant Treasurer Insurance once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surreme funeral director, page 5 should be क James A. Crawford, Sr. Florence M. Stephens BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 2 Ann Crawford 15101 Interlachen Drive, Apt. 816, Silver Spring, MD 2 20s, METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must centery Cemetery 4/13 Suitland, Maryland 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 21. SIGNATURE OF PUNERAL RESINSOP LICENSES 11800 New Hampshire Avenue Silver Spring, Maryland 20904 and completely filled in by the purial, cremation, or removal. medical 21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset end Death** the diseese or condition PENTRIWURG reaulting in death) MIDUTA event, executed within DUE TO (OR AS A CONSEQUENCE OF): TERM traumatic CERTIFICATION Sequentially list conditions, 2 DUE TO (OR AS A COL signed by the attending physician Health and Mental Hygiene prior to if any, leading to immediate PRUM all UE cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 0 Injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1) ASUUR PERFORMED? requires that апу 1 TYES 2 NO OF DEATH? Shows 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. certificate has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) ltem. **EXAMINER?** HOSPITAL: 1 TES 2 NO OR ATTENDING PHYSICIAN: A Inpatient 2 - ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify) 5 27. MANNER OF GEATN this c (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending М 1 YES 2 NO After death ΒY 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 28 Is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: / COMPLETED 4 Nomicide Rem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. FUNERAL within 72 h HOSPITAL -TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner se stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 1997 2 MESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print) and 32. REGISTRAR'S SIGNATURE PR 1995 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



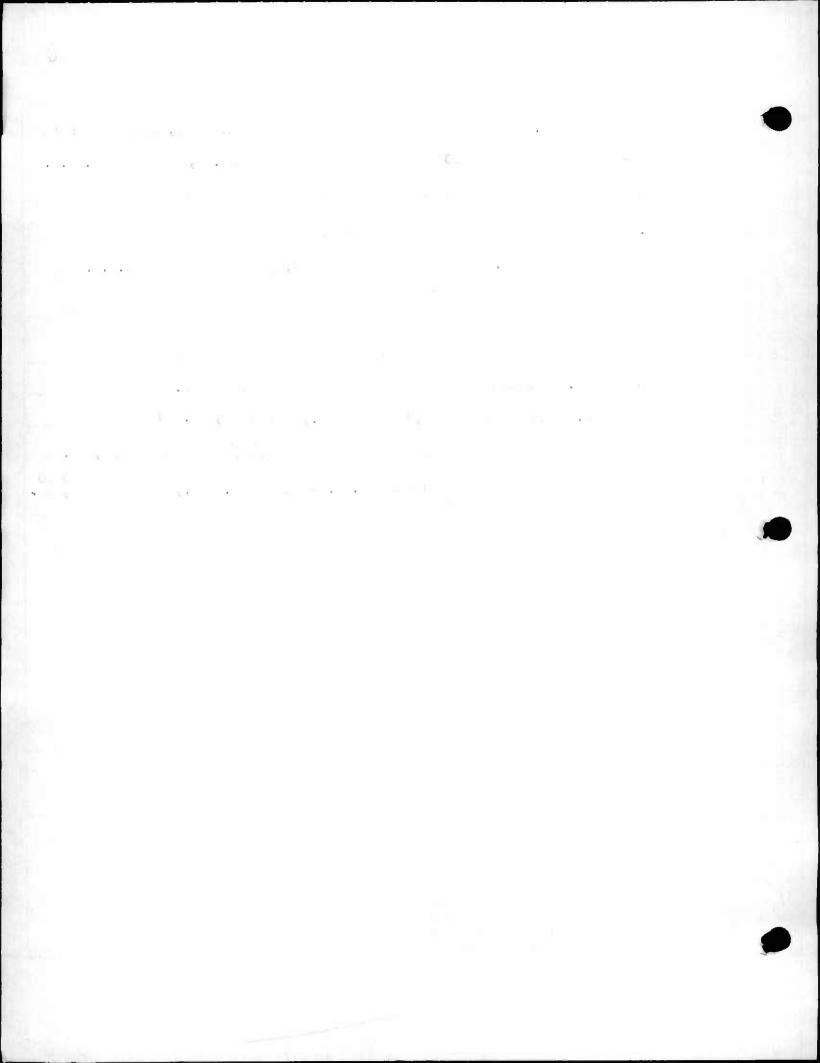
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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) THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Amours after death. Page 6 may be retained by the hospital or) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	2
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r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should TO BE COMPLETED BY FUNERAL DIRECTOR IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once, TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND N	MENTAL HYGIE		
1. DECEDENT'S NAME (First, Midd	lle, Lest)				2. DATE OF DEATH		3. TIME OF DEATH
AGNES	21 OFFICEON					13, 199	11:40 PM
4. SOCIAL SECURITY NUMBER		940	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
579-84-4952 9a. FACILITY NAME (If not institution	22			1 2	SEPT. 26	_	WASH. D.C.
	ARDENS NURSING C			INGTON	АТН	9c. COUNTY	OF DEATH TGOMERY
10a. STATE 10b.	COUNTY	t0c, CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY
	PRINCE GEORGES		CAPITO	L HEIGHT	S		LIMITS?
10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZER	OF WHAT COUNTRY?
	ND PARK DR.			20743			U.S.A.
11. MARITAL STATUS 1 Never Married 2 Marrie	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XXNO	13. WAS DEC	ENDENT OF HISPANI Icify Cuban, Maxican	C ORIGIN? (Specify Y , Puarto Rican, etc.)	ea or No 14.	RACE — American Indian, Black, White, etc.
3 💹 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DAT	ES	1 TYES	2 NO Specify:		1	Specify: WHITE
15. DECEDEN	T'S EDUCATION est grade completed)	16a. DECEDENT'S US	UAL OCCUPATION	N	16b. KIND OF B	JSINESS/INOUS	
Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life, Do NOT use re	tired.)	st of working			
12		HOU	SEWIFE			AT HOM	2
17. FATHER'S NAME (First, Middle,	· · · · · · · · · · · · · · · · · · ·			18. MOTHER'S NAM	E (First, Middle, Maide	n Sumame)	
	M. MCKIMMIE						SANFORD
19a. INFORMANT'S NAME (Type/Pri					oute Number, City or To		
PHYLLIS J.					VILLE, MD		
1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	☐ Ramoval from Stata cemet	PLACE AND DATE OF D	place)		1	OCATION City	
21. SIGNATURE OF FUNERAL SER		HAMBERS (D ADDRESS OF FAC	/114/95 IUTY	RIVER	DALE, MD.
· 2/1/2/	Chamlerse	M00091	W. W.	CHAMBER	G CO. INC	.,SILVE	20910 ER SPRING, MD.
23. PART i. Enter the disease shock, or heart filmMEDIATE CAUSE (Final disease or condition resulting in death)	es, or complications that caused allure. List only one cause on each allure.	the death. Do not the line.	enter the mod	le of dying, such	as cardiac or res	piratory arrest	Approximata interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	extense of):	in				years
PART II. Other significent co	inditions contributing to death but	not resulting in ti	he underlying	cause given in P	art i. 24a, WAS A	ALITOROV	
	tishes		underlying	outse given at r	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
malne	triting				1 □ YES	2 NO	OF DEATH?
	7 7 7				-		1 TES 2 NO
25. WAS CASE REFERRED TO MED	HCAL		26, PL	ICE OF DEATH (Chec	k only one)		
EXAMINER?	HOSPITAL: 1 Inpetlant 2 ER/Outpet	lent 3 DOA 4	THER:	5 Raaldenca 8			
27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. INJU	RY AT	28d. OESCRIBE HOW	INJURY OCCUR	ED
1 Natural 5 Pendir 2 Accident Investi	19	INJUNT		ES 2 NO			
3 Sulcide 8 Could		At home, farm, stree	t, factory, office		28f. LOCATION (Street City or Town, State	and Number or F	lural Route Number,
4 Homicide detarm	ined				Only or lown, State	,	
29a. CERTIFIER (Check only one) 1. CERTIFYING	3 PHYSICIAN: To the best of my knowled XAMINER: On the basis of axaminstion a	iga, death occurred at	the time, data	and place, and due to	o the cause(a) and me me, data and placa, a	nner as stated.	use(a) and menner as stated.
29b. SIGNATURE AND TITLE OF CI				29c. LICENSE NUMB			GNEO (Month, Day, Year)
pars (1. Doss up			D239	11	DA DO	1114 1995
30. NAME AND ADDRESS OF PERS	SON WHO COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Prin		rgetoun	Road	Bethe	sda, M 1208/4
31. DATE FILED (MOOT) DOLL YOU	1995 TRAB'S SIGNAT			/		Cirit	7



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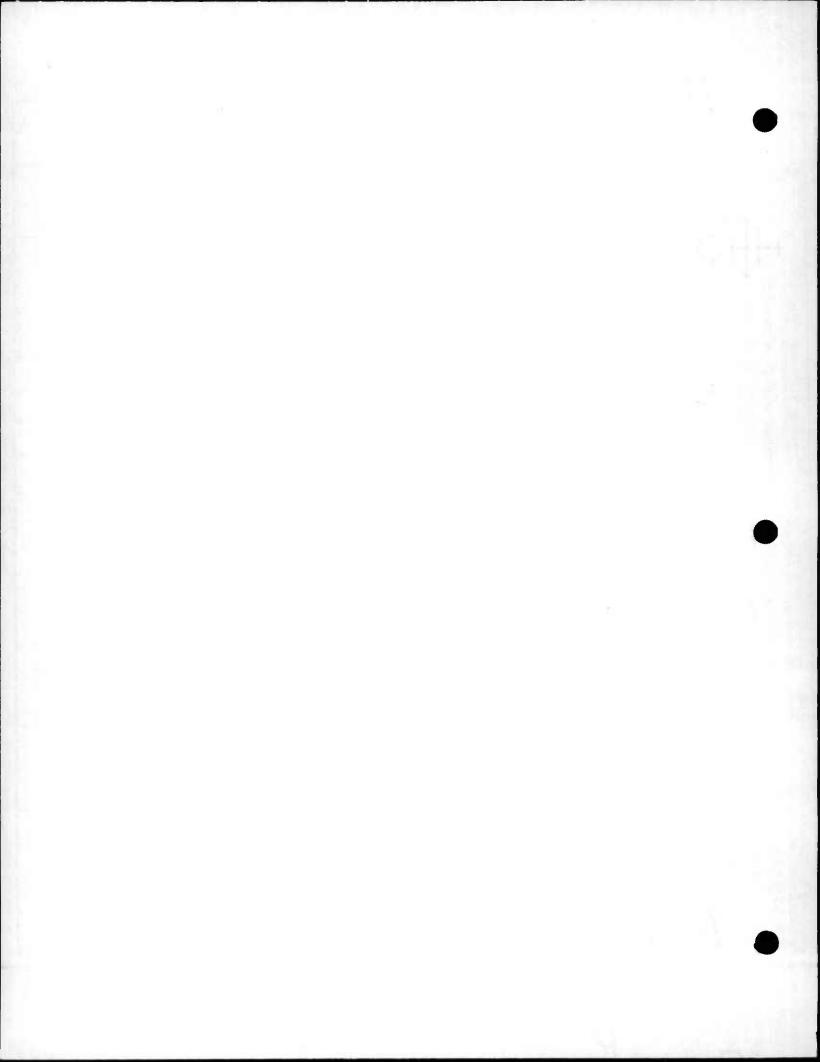
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Bernadette Connelly 1995 Helen April 16 3:00 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Dey, Year) April 3, 8. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 73 1 M 2 X F 187-12-9269 1922 Pennsylvania Ex hours after death, Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not removal. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1912 Saratoga Drive Prince Georges Adelphi RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Adelphi 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1912 Saratoga Drive 20783 USA 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puarto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 1 YES 2 X NO Specify 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Legal Secretary Law once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at William Joseph O'Rourke BE Helen Marie Healy notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 William Connelly 12006 Thackery Court, Bowie, MD 20720 9 20a. METHOO OF DISPOSITION
1 X Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Gate of Heaven Cemetery 4/19/95 Silver Spring, MD 4 Donation 5 Other (Specify) examiner 22. NAME AND AODRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE Francis J. Collins Funeral Home, Inc. teven 500 University Blvd.W. Sil.Spr. MD 20901 the medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, ahock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death cremation. disease or condition resulting in death) been signed by the attending physician and completely at of Health and Mental Hygiene prior to burial, crematic . Cardio Pulmonary Arrest event, 10 mins. DUE TO (OR AS A CONSEQUENCE OF): Amyotrophis Lateral Sclerosis traumatic 9 mons. CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST 6 injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 TYES 2 NO shows a 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) certificate h HOSPITAL: 1 YES 2 NO OTHER: Inpatiant 2 ER/Outpatiant 3 DOA 4 ☐ Nursing Home 5X☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c marked, 28d, DESCRIBE HOW INJURY OCCURED 1X Natural 5 Pending M 1 YES 2 NO ВҰ After t Investigation 2 Accident DIRECTOR; Af hours after de item 28 is r 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Soscify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurad at the time, data and place, and due to the cause(s) and menner as stated. TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) B D 00232 April 17,1995 9 WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) Morton Altschuler, M.D. 1299 Lamberton Drive Silver Spring, MD 20902-3411

31. DATE FILED (Month, Day, Year)

APR 19 1995

32. REGISTRAR'S SIGNATURE

Julia Davidson Reveall



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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed withher flowers after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

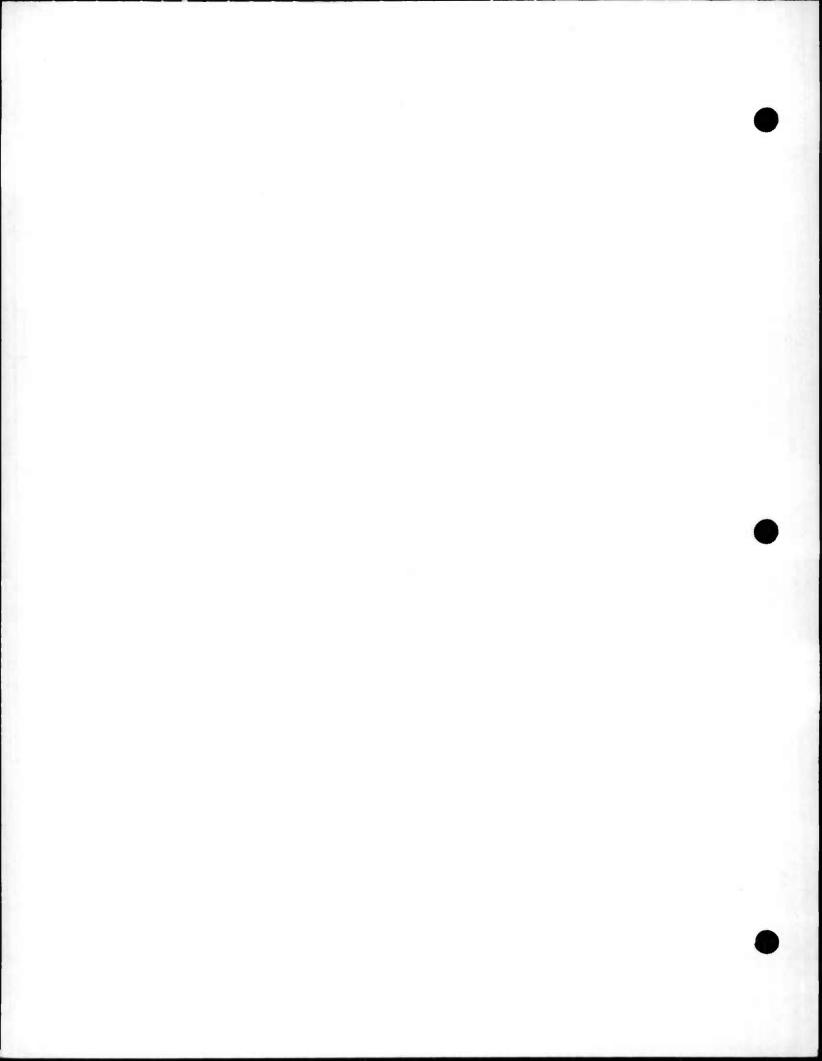
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	1 - STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR ERTIF					MENTAL	HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE	OF DEATH			3. TIME OF OEAT	н
	Miriam Talbott	Chapin							Арт	il 17	**	YEAR	6:30	ДМ
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDE	ER 1 YEAR	IF UNDER	24 HRS.		DF BIRTH	, 100		LACE (State or For	
	218-20-1379	1 🗆 M 2 🔀 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	, Day, Year)	1005	Country)	,	ayn
	9a. FACILITY NAME (If not institution, give si	treat and number)	- 00		Oh CIT	V TOWAL	OR LOCATE	011 OF D		. 30,			yland	
Œ	Fox Chase	and the second	_		90. CI						9c. COU	NTY OF DEA	ATH	
6	Rehabilitation &	Nursing	Center			Silv	ver S	prir	1g		Mo	ntgom	nery	
DIRECTOR	10a. STATE 10b. COUNTY	,		10c, CIT	Y, TOWN	OR LOCAT	TION					1	10d. INSIDE CITY	
	Maryland Mon	tgomery		1	C; 1,		Sprin	~					LIMITS?	
7	10e. STREET AND NUMBER	egomery_			DII		PET TI				10g CITI		I YES 2 X	NO
FUNERAL	2015 East West H	li ahuan									1000			
=	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	12	WAS DEC	2081		IIC OBIONI	? (Specify Yes	Un		States	
	1 Never Married 2 Merried	FORCES? 1 IF YES, GIYE W	YES 2 XI	NO		If yes, sp	ecify Cuba	n, Maxica	n, Puerto R	r (Specify rea lican, atc.)	or No-	Black,	- American India White, etc.	n,
₽	3 🛚 Widowed 4 🗌 Divorced	IF TES, GITE W	AN ON DATES			1 U YES	2 🛚 NO	Specify	/ :			Specify:		
	15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL (OCCUPATION	ON		16b.	KIND OF BUS	INFSS/INC		White	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	(G	ive kind of a	work done se retired.	during mo	st of workin	g						
그리		4	´	Home	make	2r				Own H	lomo			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			1101110	mare	-1	18. MOTH	IER'S NA	MF (First M	fiddle, Maiden				
	Otho H.W. Talbo	++							,	Choate				
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAJLING	ADDRES	S (Street a				er, City or Town		Ondel		
2	James J. Cromwell													
3			20h BLACE	22 We	STL	Jeile	rson	Str		Rockv			20850	-
	20a. METHOD OF DISPOSITION 1 Burlel 2 & Cremetion 3 Remo	oval from Stata	20b. PLACE	ematory or o	ther place	Apr	ïï. 1	8, 1	995	5-6-6		City or Town		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE . O	Monto		y Cr	emat	oriu	m, 1	nc.	Bet	hesd	a, Ma	ryland	
	RI amo	D. 00	1.	00831	Ro	bert	A	Pump	hrey	Funer	al H	ome/		
	Darbara go /c	Jacken	auren		Av	enue	, Ro	ckvi	ile,	Marvl	and	1tgom 20850	ery -2805	
	23. PART I. Enter the disease's, or c shock, or hasnt fellure. I	omplications the	caused the de	eath. Do r	not anta	r the mo	da of dyl	ng, suci	h sa card	lac or respi	ratory srr	est,	Approxima	
	IMMEDIATE CAUSE (Final	List Drily one ceu	ea Dn each line	9.									Onset and	
	disease or condition resulting in death)	Conge	stive He	art	Fai	lure								
1	resulting in disacri)		OR AS A CONSE			Larc							3 days)
z		Atria	l Fibri	llati	on								10 ,,,,,	30.00
CERTIFICATION	Sequentisity list conditions, if any, leading to immediate		OR AS A CONSE									_	10 yea	irs
Į.	cause, Enter UNDERLYING													
Ĕ	CAUSE (Disesse or Injury that initiated events	DUE TO	OR AS A CONSEC	QUENCE OF	F):								+	
F	resulting in death) LAST													
5														
4	PART II. Other significent conditions			resulting i	in the u	nderiying	g ceuse g	iven in	Part I.	24a, WAS AN . PERFOR			ERE AUTOPSY FIN	
	Carcinoma of Col	on, Strol	ke							1 YES 2		C	DMPLETION DF CA	
													YES 2 X N	,
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	IBUTE TO CAI	USE OF DEA	TH YE	s 🗆	NO E	UNC	ERTAIN					A	1
X	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT										-
Sign	EXAMINER? 1 Tes 2 No	HOSPITAL:	ER/Outpatient 3	DOA	OTHE		a 5 □ Bar	aldanca	6 🗆 Other	(Specific)				
	27. MANNER OF DEATH	26a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ		and ence		CRIBE HOW IN	JURY OCC	URED		
	1 Natural 5 Pending	(Month, De	ly, Year)	1NJ	URY M	WO	RK? 'ES 2	NO						
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — At ho	me, farm, s	rtreet, fac			110	28f. LOCA	TION (Street a	nd Number	or Bural Bou	to Number	
	4 Homicide determined	building, a	etc. (Specify)						City o	Town, State)		resett 1900	tratement,	
COMPLETED	29a. CERTIFIER			-0-0-0										
₩ P	(Check only 1 23 CERTIFYING PHYSIC	AN: To the beat of	my knowledge, de	ath occurre	d at the	lime, date	and place,	end dua	to the caus	e(e) and man	ner as atate	d.		
8	one) 2 MEDICAL EXAMINER	to on the peals of ax	amination and/or i	investigatio	n, In my	opinion, de	eath occur	ed at the i	time, date a	and place, and	dua to the	cause(a) a	nd manner as sta	rted.
l w l	29b. SIGNATURE AND TITLE OF CERTIFIER	10	11				29c. LICE						fonth, Day, Year)	
0 8	Stephen C	Umu	rel V	n.s	0		0	13	90	ľ	14	-18	-95	
	30 NAME AND ADDRESS OF DEDSON WHO	COMPLETED ONLD			A 777						-			

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4-18-95

Cromwell, M.D.

Stephen C. Cromv 31. DATE FILED (Month, Day, Year) APR 19 1995 615 West Montgomery Avenue, Rockville, MD 20850

Talia Daudson Rardall



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31. DATE FILED (Month, Day, Year)

APR 20 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle Leet) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Mary Elizabeth Cavey 1995 April 17. 9:50 am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS 579-14-9260 1 M 2 K F 85 Dec. 17, 1909 Washington, DC Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery permit. I Montgomery Village 1 YES 2 K NO FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 10141 Gravier Court 20879 United States executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)

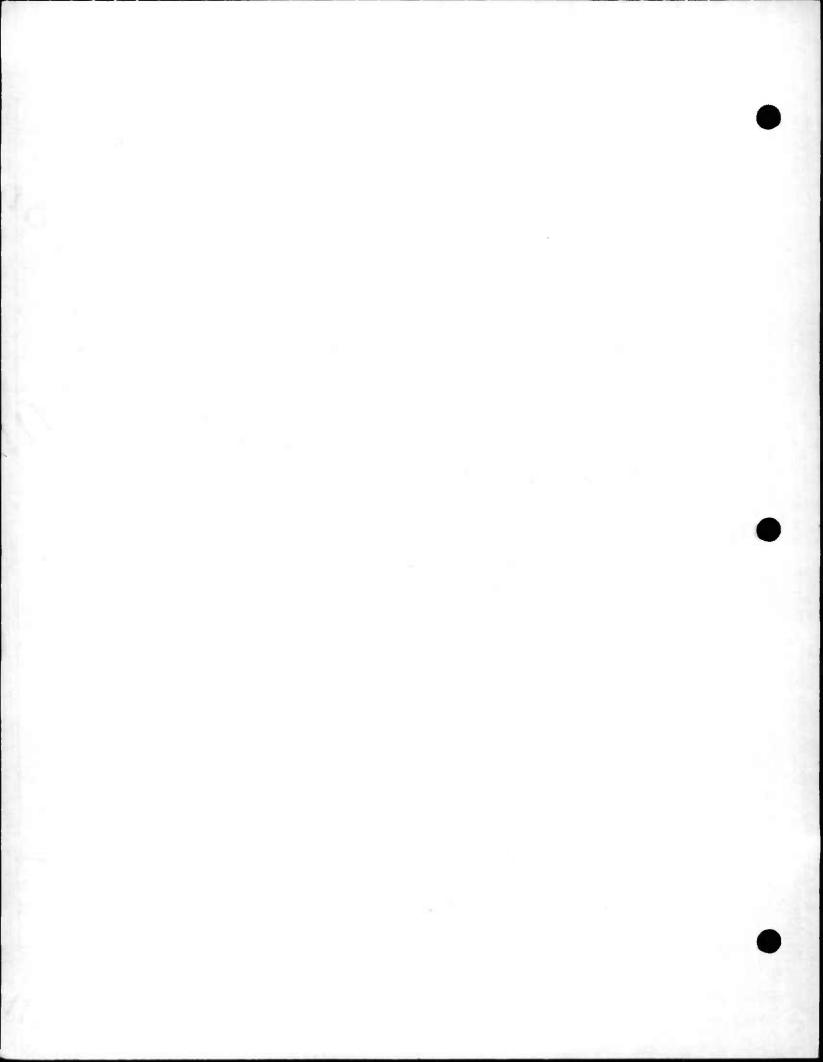
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 🔀 Widowed 4 🗌 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Telephone Operator National Institute of Healt 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname, at a Michael J. Moran BE Catherine McDonough notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joyce Murphy 10141 Gravier Ct. Montgomery Village, MD 20879 pe 20b. PLACE AND OATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Stata must cametery cromappry or other place)
Gate of Heaven Cemetery 4/20/95 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive who Gaithersburg, MD 20877 filled in by the medical 23. PART i Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximata ŏ interval Between IMMEDIATE CAUSE (Final Onset and Daath event, the disease or condition_ and completely fi burial, cremation resulting in death) 10 day traumatic CERTIFICATION been signed by the attending physician and out, of Health and Mental Hygiene prior to buri Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING 8 death certificate CAUSE (Disease or injury other that initiated eventa reaulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. the MEDICAL WAS AN AUTOPSY PERFORMEO? 206 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? law requires that any 1 TYES 2 X NO 1 - YES 2 - NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) this certificate has be with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) Hem HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: t TYES 2 X NO 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. OESCRIBE HOW INJURY OCCURED marked, 28c. INJURY AT WORK? 1 X Natural 5 Pending 1 YES 2 NO DIRECTOR: After to hours after death v BY 2 Accident 3 Suicide 28a. PLACE OF INJURY — At homa, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 18 COMPLETED 8 Could not be 4 Homicide tem 29a. CERTIFIER t 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, data and placa, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examin allon, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Yes 302 W - 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT)

Vicente C. de Guzman, MD 10215 Ferwood Rd #504, Bethesda, MD 20817-1106

32. REGISTRAR'S SIGNATURE

Daviden Rose

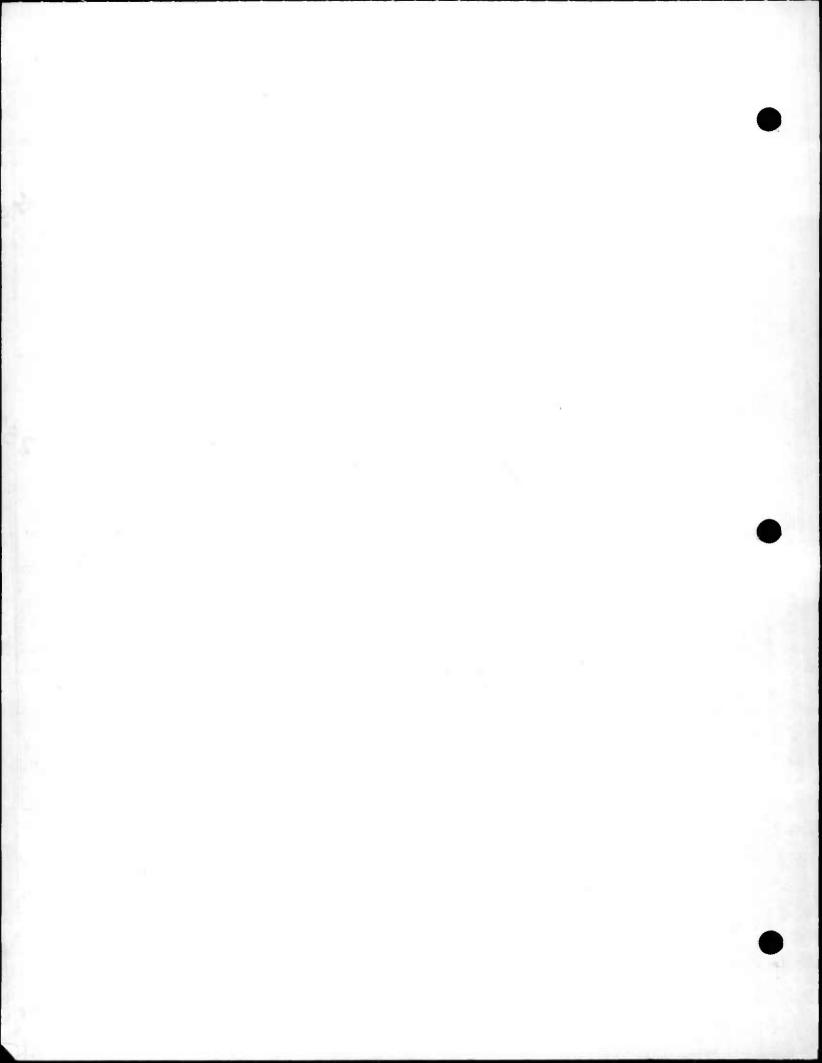
OHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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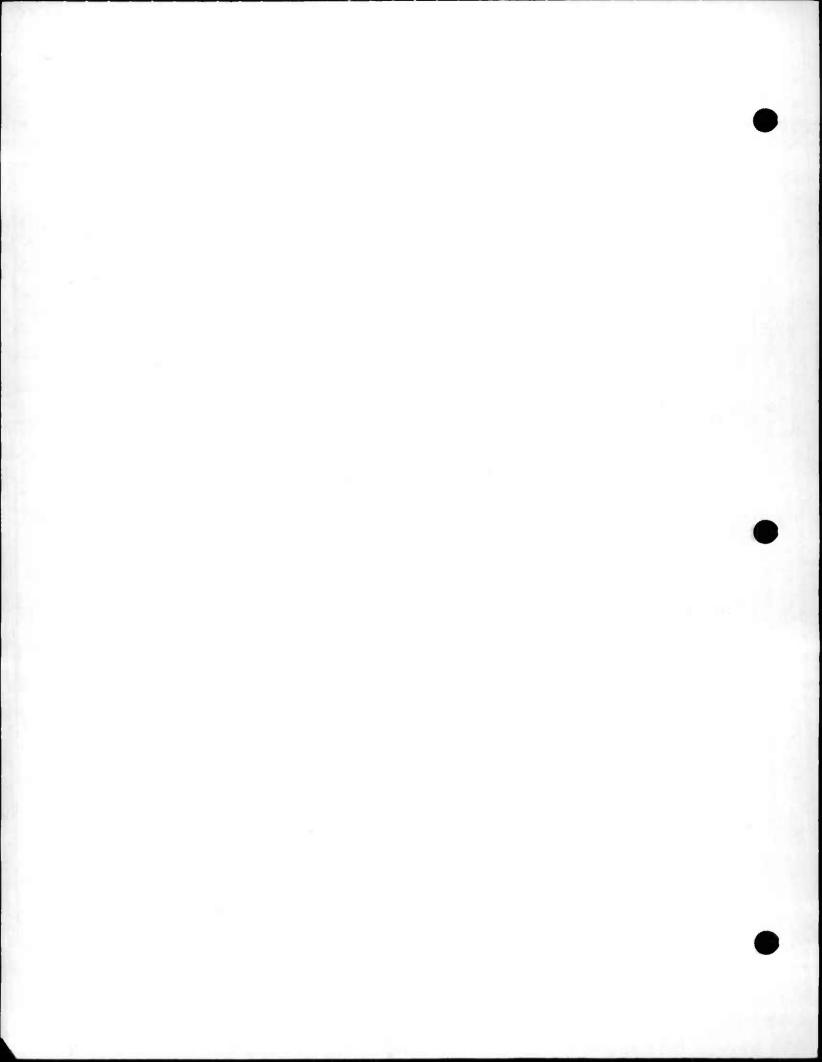
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	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAR CERTIF	TMENT OF H			YGIENE EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	DEATH			3. TIME OF DE	ATH
	HARRY WHITE	CULBRET	Н			APRTL	19.	19	95	9:45	Рм
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	нятн			PLACE (State or	1000
	275-16-6120	€ M 2 🗆 F	90 YAS.	MONTHS DAYS	HOURS MIN.	Sept 1	/ Year)	904	Countr	ginia	
	9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN (OR LOCATION OF OR		· · · ·		V III		
E E	6909 Marbury Road			Betheso	da				tgom		
DIRECTOR	RESIDENCE OF DECEDENT			Dounes				HOH	Lyom	er y	
R	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION				T	10d, INSIDE CI	TY
	Maryland Montgo	omery	Be	ethesda						1 YES 2	NO NO
AL	10e. STREET AND NUMBER			101	. ZIP CODE			10g. CITI	ZEN OF W	VHAT COUNTRY	7
FUNERAL	6909 Marbury Road			2	20817		ı	Uni	ted	States	
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ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OF			ecify Cuban, Mexica 2 X NO Specify		, etc.)		Specia	h:	
										White	9
TE	15. DECEDENT'S EDUCATION (Specify only highest grade company)	DN pleted)	16a. DECEOENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATION WORK done during mo	ON est of working	18b. KJN	D OF BUSI	NESS/IND	USTRY		
7	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	25 - 25 - 25	,		_					
COMPLETED	17, FATHER'S NAME (First, Middle, Last)	4	Executi	.ve	,		uran				
		Culbreth			18. MOTHER'S NA			_			
BE	Henry Clay 198. INFORMANT'S NAME (Type/Pring)	COTDLECU			Henrie			sely		Hooper	
5	Mary Elizabeth Culb	reth (Wif	e) Same a		nd Number or Rural I	Route Number, C	ity or Town,	State, Zip	Code)		
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramoval	Imm State	20b. PLACE AND DATE	OF DISPOSITION (No	me of	OATE	20c. LOC	ATION —	City or Tox	wn, State	
	4 Donation 5 Other (Specify)	Trom State	cemetery, crematory or o Chesapeak	ie Cremat	COLA	4/20	Bel	tsvi	lle,	MD	-
	21. SIGNATURE OF FUNERAL SERVICE LICENSE			22, NAME A	Uneral S	CILITY					
	Sell RPL	//	M00007						***	00040	
	28. BART I. Enter the diseesea, or comp		M00827	1900 61		SILVER	Snr.	חח	MILI	20910	
		olications that cau	sed the death Do	of enter the me	st Ave,	OTTACI	Opi.	ing,	MU		
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	IMMEDIATE CAUSE (Final	only one cause of	sed the death. Do no each line. A A CONSEQUENCE OF	not anter tha mo	no Hale	h as cardiac	or respire	etory arr	ast,	Approxi	Between
N.	IMMEDIATE CAUSE (Final disease or condition resulting in death)	only one cause of	CFAST	not anter tha mo	de of dying, suc	h as cardiac	or respire	etory arr	ast,	Approxi	Between
TION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	OUE TO (OR A	CFAST	ARCIA	no Hale	h as cardiac	or respire	etory arr	ast,	Approxi	Between
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1 - FOR STATE REGISTRAR

4. SOOLA SECURITY NUMBER S. SEX S. AGE (Pr. pr. inet birtholy) Modern Location of Death C. Company C. C. C. S. S. S. S. S. S. S. S. S. S. S. S. S.			1. DECEDENT'S NAME (First, Thomas Nel			D.						MONT	of DEATH	199	YEAR	3. TIME OF OEATH 7:30 PM
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020	fours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	I THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the month of the footbill the footbill the footbill or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 so within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1. DECEDENT'S NAME (First, Middle, Las	st)	, 11		IOAIL	OF	DEA	ТН	2. DATE	OF DEATH	AY	YEAR 3.	TIME OF DEATH
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COMPL	17. FATHER'S NAME (First, Middle, Last) Earl Mitchell (Craic C-							, ,	Middle, Meiden Adsit	Surname)	TY	
8	19a. INFORMANT'S NAME (Type/Print)	craig, Sr		9b. MAILING	ADDRESS	(Street a				ber, City or Tow	n State Zin C	Corde) O	0006
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Audrey Clarice Carl April 9. 1995 4. SOCIAL SECURITY NUMBER 8. AGE (in vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1920 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State 220-10-3255 1 M 2 X F Maryland YAS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington County Hospital DIRECTOR Hagerstown Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION
Smiths burg 10d. INSIDE CITY LIMITS? Md. Washington permit. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A 120 Water St. West 21783 funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-**BALTIMORE, MARYLAND 21215-0020** 14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest gra Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home. 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Bessie M. Accord Samuel H. Dayton notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jouce K. 13135 Goldizen Lane Clear Spring, Md. 21722 Kindle pe 20a, METHOD OF DISPOSITION
1 Description 2 Cremetion 3 He 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Rest Haven Cemetery 4-12-95 Hagers town. Md. examiner 21. BROWNTURE CO. PUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY 12525 Bradbury Ave. Davis Funeral Home n by the fi Smithsburg, Md. 21783 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, filled in by shock, or heart fallure. List only one ceuse on each line Interval Batween 9 **IMMEDIATE CAUSE (Fine)** Onset and Death in and completely fille to burial, cremation, the disease or condition resulting in death) 10 days umon event, DIVISION OF VITAL RECORDS, P.O. BOX 68769 OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. OR ATTENDING PHYSICIAN: The law requires that the MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Mah 207 pur ger PERFORMED? any 1 TYES 2 THO shows a DF DEATH? 1 YES 2 ND t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only or certificate h. Item HOSPITAL: OTHER: 1 TYES 2 THO tient 2 🗆 ER/Outpatient 3 🗎 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, TIME OF 28d. DESCRIBE HOW INJURY OCCURED this c 1 Natural 5 Pending BY 1 YES 2 NO After 1 death 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. - 649 6 Could not be DIRECTOR: / 4 Homicide 28 determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2: 29a. CERTIFIER COMPLI 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mennar as stated. 29b. SIGNATORE, AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 01982

OEATH (ITEM 27) (Type, Print)

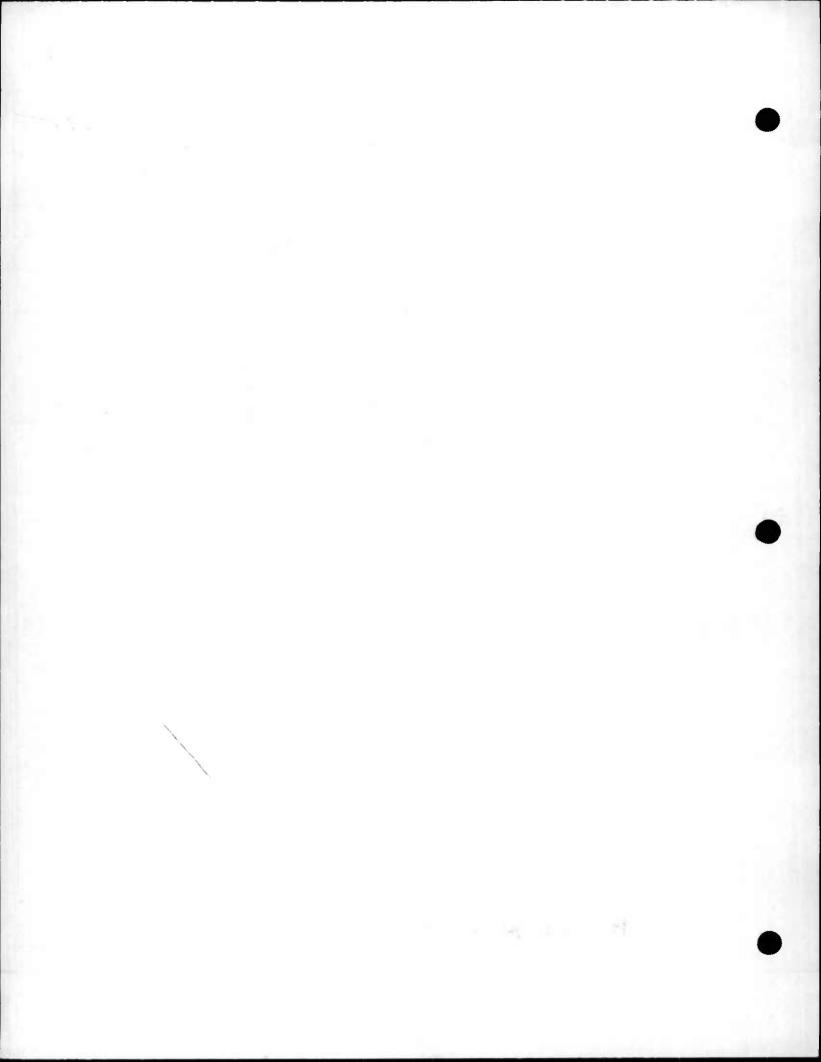
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30. NAME AND ADDRESS OF PERSON WHO COM

2 1995

GLORIA



3. TIME OF DEATH 1135 AM

> Approximata Intarval Between Onset and Death 10 DAYS

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

29d. OATE SIGNED (Month, Day, Year) 04-16-91

HAGORIFORNA MB 21742

REG. NO.

		1414D		Hilda La	quise	Carpe	r			MONTH	F DEATH		YEAR 3	1135 A
		4. SOCIAL SECURITY NUM		5. SEX		yrs, last birthda) IF UND	ER 1 YEAR		7. DATE OF	F BIRTH Day, Year)			LACE (State or Foreign
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3 should	CC	9a. FACILITY NAME (# not			- 7				N OR LOCATION OF D	DEATH		9c. GOUNT	1	/
2	DIRECTOR	Washington	CEDENT	y nospita	3.T.		На	iger	stown			WAS	hing	Ton
Segr	E E	10e. STATE	10b. COUNTY				ITY, TOWN						1	IDD. INSIDE CITY
mit. F		Maryland		ington		Ha	agers	-						YES 2 X NO
020 physician. burial-transit permit. Pages 1,	FUNERAL	20102 Jeff		272					10f. ZIP CODE					AT COUNTRY?
cian.	1 2	11. MARITAL STATUS	erson i	12. WAS DECEDEN	IT EVER IN U	S. ARMEO	11	WAS D	21742	NIC OBIOINS	U.S.A. (Specify Yea or No. 14. RACE - An			1 1 1
9 2 2	B	1 Never Married 2 3 Wildowed 4 Div	and the second second	FORCES? 1 IF YES, GIVE Y	YES :	2 NO		If yes,	specify Cuban, Maxic ES 2 MO Speci	an, Puerto Ric	can, etc.)	or No.	Black, \ Specify:	American Indian, White, etc.
			CEDENT'S EOUC		16	Se. DECEOENT	of work don	e durina i	TION most of working	18b. K	IND OF BUS	SINESS/INOU		
YLAND 21: by the hospital or be detached for u	COMPLETED	8 years	(0-12)	College (1-4 or 5		Homema	use retired.)		Personal Residence				ice
	8 00	17. FATHER'S NAME (First,	Middle, Last)					16. MOTHER'S NAME (First, Middle, Maiden Surname)						
		George 19a. INFORMANT'S NAME	7	Kr	nepper			Agnes K. Bumbaugh						
MAR\ retained to 5 should	TO BE	C. Lee Le							mand Number or Aurel nger Mill					21742
may be	2	20a. METHOD OF DISPOSI	TION		20b. Pt	ACE AND DAT				OATE	_	CATION — CI		
OF m e 6 m	must	1 X Burlel 2 Cremati 4 Donation 5 D Other		oval from State	cemeter Mt	ry, cremetory of	other plece	ter	y 4–19–1	995				ylvania
ALTIMORE, death. Page 6 may be funeral director, page	examiner	21. SIGNATURE OF FUNER	AL SERVICE LIC	ENSEE			22	2. NAME	AND ADDRESS OF FA	ACILITY				yivania
	ехаи	1 / //01	wola.	N Fi	nu		D	oug]	las A. Fid	ery Fu	neral Hage	l Home	e m. M	arvland
VIESE	medical	23. PART L Enter tha	disamsea, or c	emplications tha	t caused th	ne deeth. Do	not ante	er tha n	node of dying, suc	ch es cerdia	c or respi	retory arres	Bt,	Approximata
5 8 9 9	the m	IMMEDIATE CAUSE (FI	nai											Onset and Dea
tely matri		disease or condition resulting in death)	→ ,	PNE	UMOI	NIA					_			10 DAY
68760 recuted within and completely burial, cremati	event,			DUE TO	(OR AS A CO	ONSEQUENCE	OF):							
K 6876 executed n and com to burial,	ry, or other traumatic	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												
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	other TIFIC	thet initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
P.O. eath certification partending partendin	ER C	resulting in death) LAS	٥											
Mer de d		PART ii. Other algnific	ant conditions	contributing to	death but	not resulting	In the u	ındariyi	Ing cause given in	Part I. 2	4a. WAS AN			ERE AUTOPSY FINDING
Signed by Health and	S (§	BALERIOSC	LAROTI	c HEART	DISE	FIBE W	retat	COA	10037106		PERFOR		C	WAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
REC requires een sign of Healt	shows : MEC			16 URG										YES 2 NO
> 0 +1		DID TOBACCO U		RIBUTE TO CA	USE OF I	DEATH \	ES 🗆	NO I	UNCERTAL	N 🗆				
는 무 원 등	PHYSICIAN	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:		PLACE OF DE	OTHE		0)					
II 2 5 5	14S	1 VES 2 NO		16 Inpetient 2 28a. DATE OF		_	4 🗆 Nu	v -	ome 5 Residence					
O \(\xi \) \(\xi \)		1 Natural 5	Pending	(Month, D	lay, Year)		YAURY	V	YES 2 NO	26d, DESCH	HIBE HOW I	NJURY OCCU	RED	
ON DING After death		2 Accident 3 Suicide	Investigation Could not be	28s. PLACE O	F INJURY -	At home, farm	, street, 1e			281. LOCATI	ION (Street a	ind Number or	Rural Rou	ite Number,
DIVISION OR ATTENDING DIRECTOR: After hours after death	28 H	4 Homicide	determined	building,	atc. (Specify)					City or	Town, State)			
DIV L OR A DIREC	Item PLE	29a. CERTIFIER (Check only	TIFYING PHYSIC	CIAN: To the best of	my knowledg	ga, death occu	rred at the	time, de	ite and place, and due	to the cause	(a) and man	nor as stated		
HOSPITAL FUNERAL within 72 I	E NO								death occured at the					nd manner as stated.
THE HOSPI THE FUNER filed within	토Ш	296. SIGNATURE AND TITL	F OF CERTIFIER						29c. LICENSE NU	MBER		29d, OATE S	SIGNED (M	fonth, Day, Year)
THE BE		1 hourshill		0					12200		- 1	P 0		-

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8 1995

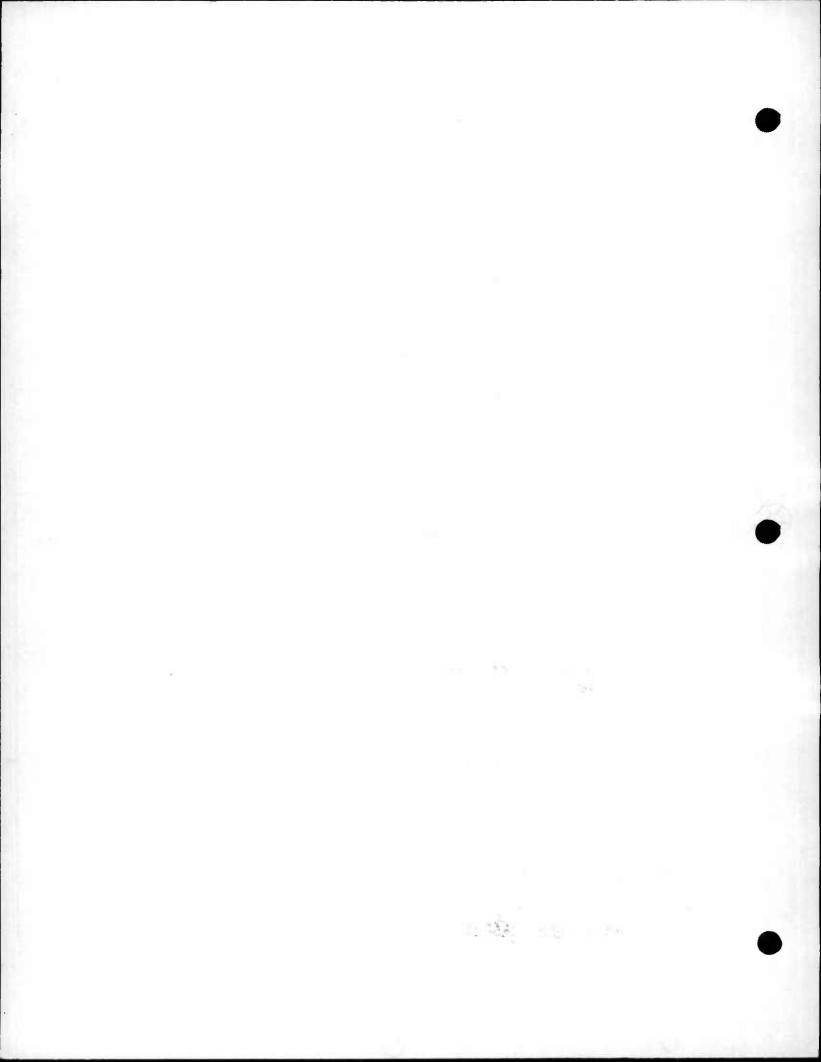
BARRY .M.

APR 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

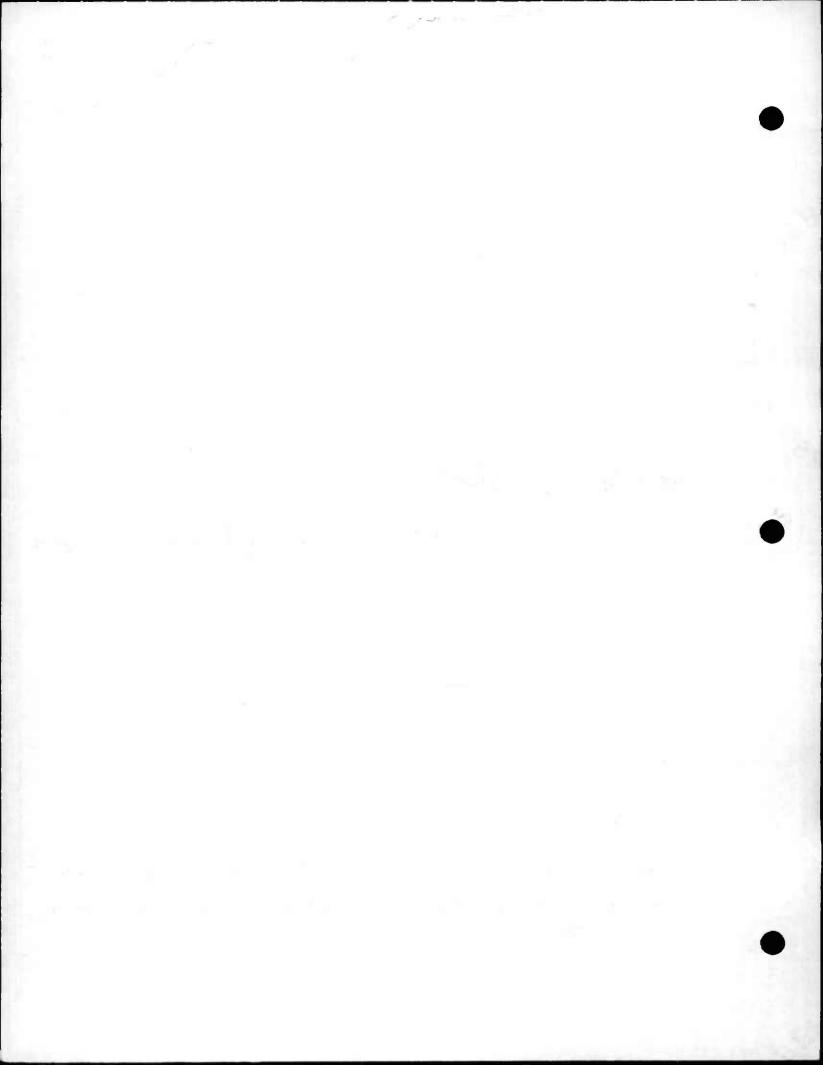
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DHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

									- 01			REG. NC			
			1. DECEDENT'S NAME (First	, Middle, Last)	Lionel							2. DATE OF DEATH			3. TIME OF DEATH
	,		Kenne	eth	L. Cori	nwe11							3 19	95	9:40P M
			4. SOCIAL SECURITY NUMBER	BER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS	7. DATE OF BIRTH	3 13 T		PLACE (State or Foreign
	,		230-56-3331		1 🔀 M 2 🗆 F	90	YRS.	MONTHS	DAY8	HOURS	MIN.	(Month, Day, Year)	4005	Country	()
	용				/ /	90	rno.					March 27	1905		nsylvania
	3 should	-	9e. FACILITY NAME (If not In	istitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATION	ON OF DE	ATH	9c. COUN	ITY OF DE	EATH
	2, 3	Ö	Ginger Cove	e Heal	th Cente	r		l	An	napo	lis		Ann	e Ar	undel
		DIRECTOR	RESIDENCE OF DEC												
	age	2		10b. COUNT			10c. CIT	Y, TOWN (tod. INSIDE CITY LIMITS?
	if.	. 1	MD	Anne	<u> Arundel</u>				Anna	apoli	S			- 1	1 YES 2 NO
	pera	¥	10e. STREET AND NUMBER						101	. ZIP CODI	E		10g. CITIZ	ZEN OF W	HAT COUNTRY?
	physician. burial-transit permit. Pages 1,	FUNERAL	1104 River	Cresce	ent Drive	9					214	101	Lloi	+	Ctataa
0	ician al-tra	3	11. MARITAL STATUS		12. WAS DECEDEN	NT EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT C	F HISPAN	IIC ORIGIN? (Specify Ye			States - American Indian,
32	phys		1 Never Married 2 🔀		FORCES?	YES 2	NO		If yes, sp	ecify Cube	n, Mexica	n, Puerto Ricen, atc.)	00	Black.	, White, atc.
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15	ttend e as	요	15. DEC	EDENT'S EDU	CATION	16e.	DECEDENTS	USUAL O	CCUPATIO	ON		16b. KIND OF BU	CINEGOUND		
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Z	the hospit detached once.	COMPLETED	17. FATHER'S NAME (First, M		5		01111	001 4	100					01 /	Tilly
Z	de de	8		.,,						18. MOT		ME (First, Middle, Melder			
~	d by	H	Elmer G. (11							ce D. McCc			
MARYLAND	retained by the hospital or 5 should be detached for unotified at once.	0	190. INFORMANT'S NAME (7				19b. MAILING	ADDRESS	S (Street e	nd Number	or Rural F	Route Number, City or Tox	rn, State, Zip	Code)	
	De re	-	Jean M. Co	rnwel			1104 F	River	Cre	escer	nt Dr	ive Anna	polis	, MD	21401
BALTIMORE	after death, Page 6 may be by the funeral director, page moval,		20a. METHOD OF DISPOSIT		Salli, v.S., s.	20b. PLA	CE AND DATE	OF DISPOS	ITION /Na	me of	4	/ 1 CD/TEC 20c. LC			
Ö	the funeral director, page of may the funeral director, page.		1 X Burial 2 Cremetic	n 3 ∐ Rem (Specify)	oval from State	cemetery.	Pauls	ther place	ed N	/etho	diet	Cem Lu	sby, N	Mary	Land
Σ	Page 1 dire		SIGNATURE OF FUNERA		ENSE	pt.	lauis	22	NAME AN	ID ADDRES	S OF EA	Cuttobn M	Toylo	vial y	neral Home
	death. Pag funeral div f. examiner		1) 1/	10	41	//									
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	d in by the or removal, medical e		23. PART I. Enter the di	lseeses, Dr	omplications the	t caused the	deeth. Dp i	Dt anter	tha mo	de of dyi	ng, auch	n as cardiac or reap	Iratory arm	net.	Approximate
N.	3 - 2		arrock, Dr n	eart failure.	List only one ceu	use on each i	ina.						,		Interval Batween
	Political Parties		IMMEDIATE CAUSE (Fir disease or condition	nal	~/	/	- 1	1.		0		1.		V	Onset and Death
0	ed within 24 ompletely filling, I, cremation, event, the		resulting in death)	→	a. Chro	meoo	struc	twe	Pu	More	van	y disea	ge		nany years
92	uted within 24 h completely filled rial, cremation, c				DUE TO	(OR AS A CON	SEOUENCE O	F):	V			8			
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×	be excian a ior to	CERTIFICATION	If any, leading to imme-	diate	DUE TO	(OR AS A CON	SEOUENCE O	ក):							
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<u>.</u>	nding phi Hygiene	E	that initiated events		DUE TO	(OR AS A CON	SEOUENCE O	F):							
Д.		8	resulting in death) LAS		d										
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30	by the and N	4	PART II. Other algnifice	nt condition	a contributing to	death but no	t reculting	in the un	derlying	cenee 3	iven in I	Part I. 24a. WAS AN PERFOI			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
OR	uires that signed t Health a DWS any	MEDICAL										t 🗆 YES 2			COMPLETION OF CAUSE
S	requires that the een signed by the of Health and M shows any Inju	E I													DF DEATH?
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AL	PHYSICIAN; The law this certificate has bi with the State Dept.	IAN:	25. WAS CASE REFERRED TO				ACE OF DEAT			. 5110	-1/1///11	·A			
Ϋ́	N: The icate h	SICI/	EXAMINER?		HOSPITAL:		T	OTHER	3:						
>	icial the the	HYS	27. MANNER OF DEATH		1 Inpatient 2 I						sidence	6 Other (Specify)			
OF	NG PHYS frer this c eath with marked,	مَ	¥	Pending	(Month, D		26b. TIM INJ	URY	28c. INJI WO	RK?		26d. DESCRIBE HOW I	NJURY OCC	URED	
Z		B		rwestigation				M		ES 2	NO				
010	O A D W			Could not be	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, farm, a	rtreat, facto	ory, office	1	T	261. LOCATION (Street : City or Town, State)	and Number o	or Rural Ro	oute Number,
DIVISION	DIRECTOR: After hours after death item 28 is ma	ETE	4 Homicide	determined								ony or norm, orano,			
	DIRE DIRE hours	ا ي	290. CERTIFIER t CERT	IFYING PHYSI	CIAN: To the heet of	my knowledge	death occurs	ed at the ti	ma data	and alass	and do	to the cause(s) end me			
		COMPL										to the cause(s) end mei time, date and place, er			IE. IVI VIA PAR
	HOSPITAL FUNERAL WITHIN 72 P	8				ALL MARKET LINE	or investigatio	on, an may o	ринон, о	min occun	PO AT THE	time, date and place, er	d dua to the	ceuse(s)	and manner as stated.
	PORT	BE	296. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	NSE NUM	BER	29d. DATE	SIGNED (Month, Day, Year)
	TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	2	Charles V	1, 4	mizen					りつ	155	128	► Ao	ril 1	14, 1995
		F	30. NAME AND ADDRESS OF	PERSON WH	COMPLETED CAUS	SE DF DEATH (I	TEM 27) (Type,	Print)					1		
			Charles	W. I	Sinzer	MD	182	3A	Fore	d T	20	Annapol	L N	1D	2.14.01
			31. DATE FILED (Month, Day,	Year)		R'S SIGNATURE		/ 1 1	-16	30	111	JIIIIA	-0 1 1V	12	21101
	<u>. I</u>		31. DATE FILED (Month, Day, APR 19	1995	Juli As	volen Ro	rofa IL								ď
		100													



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BY

BE COMPLETED

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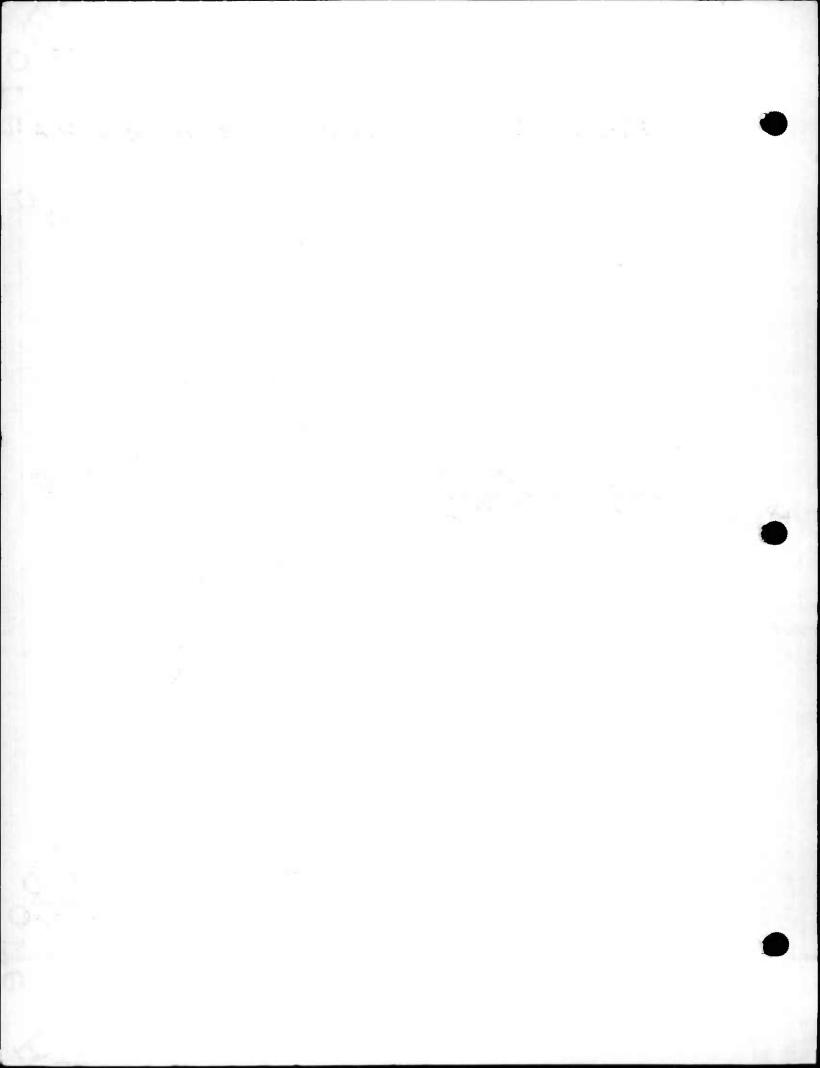
31. DATE FILED (Month, Day, Year)
APR 1 9 1995

LA DEURIS SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Tomer ossie 5170 6. AGE (In yrs. lest birthday 5. SEX 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 459-32-4298 Aug 26 1915 1 - M 2 X F 79 Ok lahoma 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Trinity Nursing Center Baltimore Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO MD Baltimore Baltimore 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2401 Gwynnoak Avenue 21207 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
 If yes, specify Cuban, Mexicen, Puerto Rican, etc.)
 \(\subseteq \text{ YES 2 \sqrt{NO}} \) NO Specify: 14. RACE — American Indian, 1 Never Married 2 Merried BY SpecifiWhite ₩idowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high nentary/Secondary (0-12) Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Rodgers Cordie D. L'ewellen BE t9a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elizabeth Seiler 2119 St. L'ukes L'n. Baltimore, MD 21207-4470 20a METHOD OF DISPOSITION 3 □ 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION --- City or Town, State Conroe Memorial Gardens 4/20/95 Conroe, Texas 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complications the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Entar ha diseases, or complications that cause the de-ahock, or heart failure. List only one cause operate line. Approximate intarvai Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) avdiony DUE TO (OR AS A CONSEQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION

Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST	DUE TO (OR AS A CONSECU-	OUENCE OF):				
PART II. Other significant condition	Contributing to death but not a	esulting in the u	indarlying causa given in		4e. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpatient 3	OTHE OTHE	26. PLACE OF DEATH (Che			
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO		RIBE HOW INJURY OCCU	RED
3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY — At he building, etc. (Specify)	me, ferm, street, fec	ctory, office	26f. LOCATI City or	ION (Street and Number or Town, Stete)	Bural Route Number,
	CIAN: To the best of my knowledge, de R: On the basis of examination and/or					
296. SIGNATURE AND TITLE OF CENTIFIER	Det, mo		29c. LICENSE NUM	127/	29d, DATE 5	SIGNED (Mapth, Day, Year)
30. WAME AND ADDRESS OF PERSON WHO	1 \// A	Oer	156mg	40	2178	y Steven

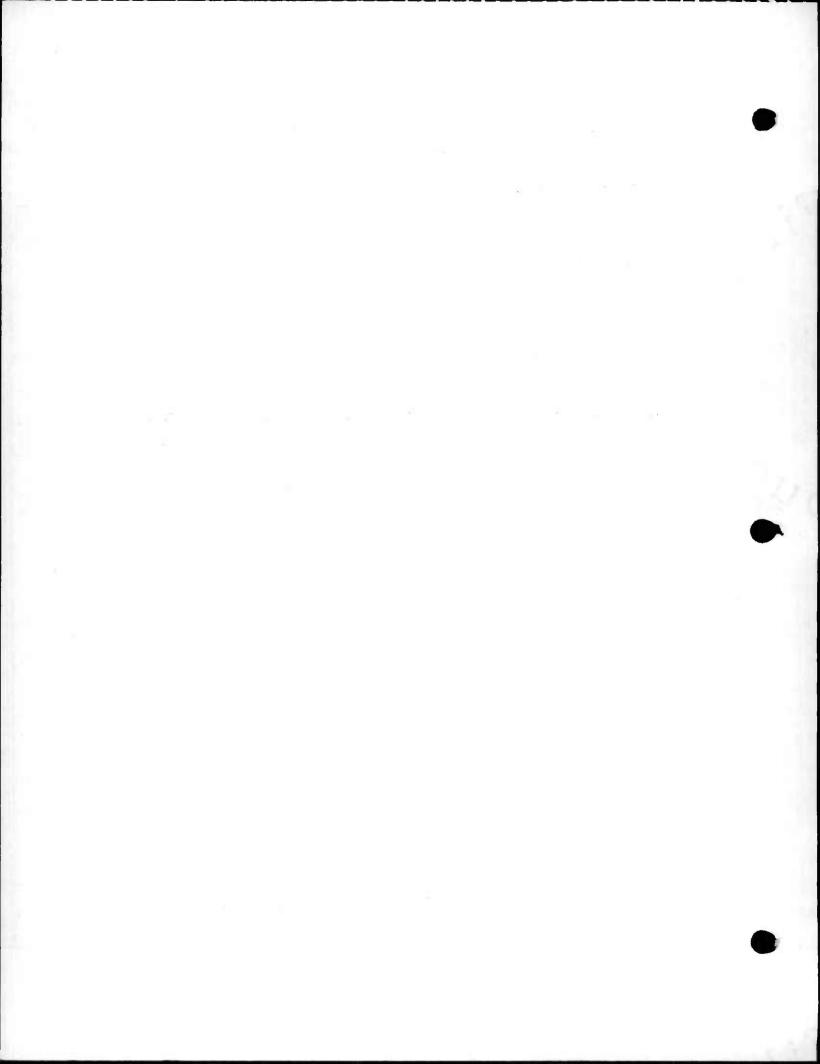


by the hospital or attending physician. I be detached for use as the burial-transit permit. Pages 1, 2, 3 should DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

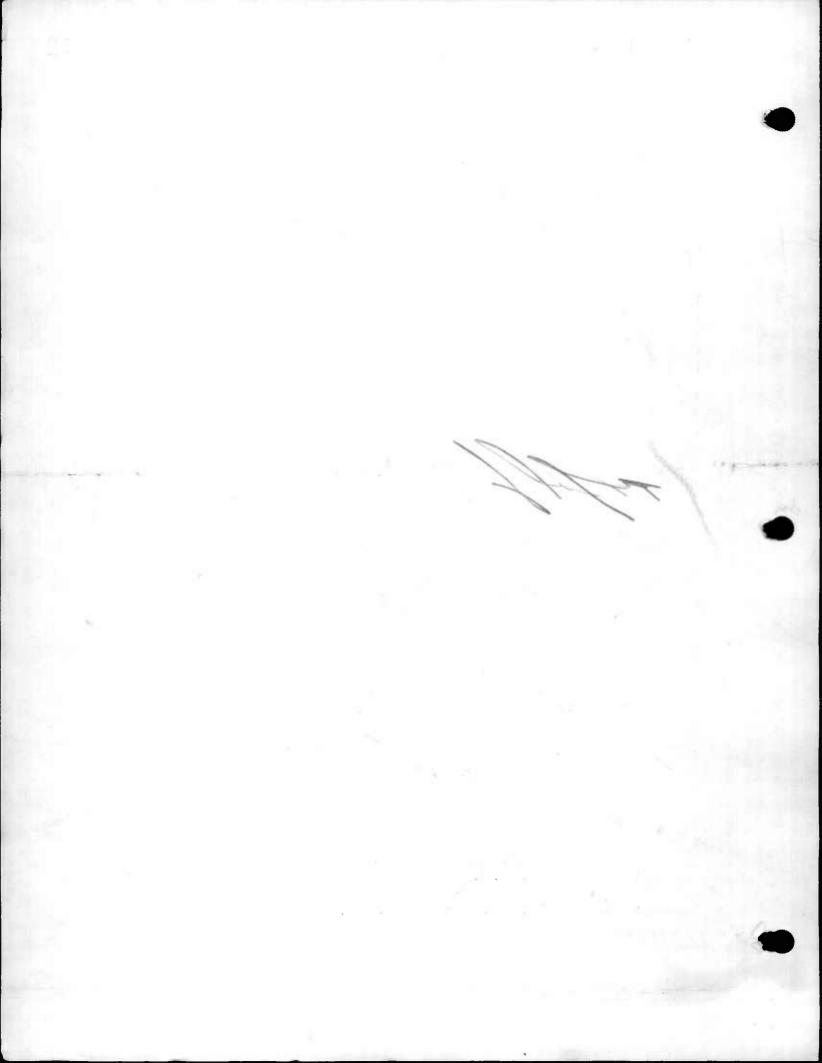
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTA	L HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)					T 2. DATE	OF DEATH		3.	. TIME OF DEA	TM
TOSEPH			CAG	ER	MONT	TH DV		EAR .	2:35	-
	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	- 1 4	7. DATE	OF BIRTH	8.	BIRTNPL	ACE (State or Fi	
213-32-6622	1 M 2 D F 5	57 YRS.	MONTHS DAYS	B HOURS MIN.	SEP	th, Day, Year) T. 23		Country)	YLAND	
90. FACILITY NAME (If not institution, give street			9b. CITY, TOW	N OR LOCATION OF D		1. 20	9c. COUNTY			
ANNE ARUNDEL MEDI	CAL CENTER			POLIS					UNDEL	
RESIDENCE OF DECEDENT	OHD CHILLE.						Ann	E AL	ONDEL	
10e. STATE 10b. COUNTY			Y, TOWN OR LO					10	Dd. INSIDE CITY	Y
	ARUNDEL	SEV	ERNA PA	ARK					X YES 2	NO
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEI	N OF WHA	AT COUNTRY?	
112 DENNIS ROAD				21146				US.	Α	
11, MARITAL STATUS 1 1 Never Merried 2 Merried	12. WAS DECEOENT EVER II FORCES? 1 YES	N U.S. ARMEO	13. WAS O	ECENDENT OF NISPA specify Cuben, Mexic	ANIC ORIGIN	N? (Specify Yes	or No — 14	RACE -	- American Indi White, etc.	len,
3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D.			ES 2 X NO Speci		ribert, etc.;		Specify:		
15. DECEDENT'S EDUCAT	TION	DECEDENTIE			100			BLAC	K	
(Specify only highest grade co.	mpleted)	16a. DECEDENT'S (Give kind of v life. Do NOT us	work done during .	ITION most of working	166	. KIND OF BUS	SINESS/INOUS	TRY		
	College (1-4 or 5+)		,							
12th 17. FATHER'S NAME (First, Middle, Last)		LABORE	R							
				18. MOTHER'S N			Sumeme)			
Frank CAGER 190. INFORMANT'S NAME (Type/Print)				MARY						
				et and Number or Rural						
MARTHA WOODARD				ST. APT.						
1X☐ Burlel 2 ☐ Cremetion 3 ☐ Remove	al from State 20b	PLACE AND OATE C	OF DISPOSITION	(Name of	OAT	20c. LO	CATION - CII)	y or Town,	, State	: (5.5
4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	MO	BOKI TOW		HURCH CEM		14/95	ST. M	AAKG	AKETS,	MDD
21, SIGNALUNE OF FUNELAL SERVICE LICEN	ISEE			E & SONS		TADV T	Λ (
Lavy B. Re	ese			VEST ST.				1 / 0 1		
23. PART I. Enter the diseases, Dr con	npilcetions that caused	d the death. Do n	ot antar tha r	node of dying, sur	ch es cen	diac or respi	ratory arrest	1401	Approxim	nete
shock, or heert failure. Lie	at only one ceuse on e	ech line.				10.0			intervel B	Between
disease or condition	11.		40						Onset and	
resulting in desth) s.	DUE TO (OR AS A	CONSEQUENCE OF	F)-						week	5
	1	CONSEQUENCE OF	EATLL	IRE					week	
Sequentially list conditione,	OUE TO (OR AS A	CONSEQUENCE OF	7:	-					week	2
if any, lesding to immediate cause. Enter UNDERLYING		198111111111111111111111111111111111111	,						İ	
CAUSE (Disesse or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF	·):						 	
resulting in deeth) LAST										
									<u> </u>	
PART II. Other eignificent conditions of	contributing to death b	ut not resulting i	n the underly	ing ceuse given in	Part I.	24a. WAS AN . PERFOR			ERE AUTOPSY FI	
						1 TES 2		CO	MPLETION DF (F DEATH?	
					_			l .	YES 2 1	NO
DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	F DEATH YE	S 🗆 NO	☐ UNCERTAI	IN 🗆					
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT								
	IOSPITAL: Inpatient 2 ER/Outp	patient 3 DOA	OTHER:	ome 5 Reeldence	6 □ Othe	r (Specify)				
27. MANNER OF DEATH	25e. DATE OF INJURY	28b. TIME	E OF 28c. II	NJURY AT		SCRIBE NOW IN	JURY OCCUR	RED		
1 Netural 5 Pending	(Month, Day, Year)	INJ		WORK? YES 2 NO						
2 Accident Investigation 3 Suicide S Could not be	28e. PLACE OF INJURY	— At home, ferm, s	dreel, fectory, of	fice	281. LOC	ATION (Street e	nd Number or i	Rural Rout	n Number	
4 Homicide determined	building, etc. (Spec	elly)			City	or Town, State)				
29e. CERTIFIER	N. Y. C. L. A. A. A. A. A. A. A. A. A. A. A. A. A.									
	N: To the best of my knowl									
2 MEDICAL EXAMINER:	A CONTRACTOR OF STATEMENTS (OF	il elia/or ilivestigation	n, in my opinion,	, death occured at the	a time, date	end place, end	due to the co	suse(s) en	id menner ee si	teted.
29b. SIGNATURE AND TITLE OF CERTIFIER	K			29c. LICENSE NU	MBER		29d. DATE SI	GNED (MC	onth, Day, Year)	
4	() ab			100	3 PIL	-	17	7/8:	5	
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)	0.0			0		•	
J. leitelbaum	139 01d	Solomo	MS K	d HAMA	400/	13, M.	d 21	40	/	
31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN				7	,				
APR 1 8 1995 🦪	in devolver Re	roball								



SEALIMON	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 n	INERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	executed within	and complete
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	SPITAL	INERAL (

	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF			YGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Les HILDA C	OOLING				2. DATE OF MONTH	DAY	YEAR	3. TIME OF DEATH	
1	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	APRIL		1995	HPLACE (State or Foreign	
	217-36-3888	1 □ M 2 □XF 89	YRS.	MONTHS DAYS		FER 1		Coun	RYIAND	
_	9a. FACILITY NAME (If not institution, give			1.2	OR LOCATION OF D			COUNTY OF		
	MEDPOINTE, 1	PRICE DRIVE		ELKTO	ON, MD			CECIL		
DIRECTOR	MD Ce	ory cil		TY, TOWN OR LOC					10d. INSIDE CITY LIMITS?	
- 11	10e. STREET AND NUMBER	CII	CII	esapeak	IOT. ZIP CODE		10	a. CITIZEN OF	1 ☐ YES 2 ▼ NO WHAT COUNTRY?	
	716 Mt Nebo	Rd			21915			USA		
	11. MARITAL STATUS 1 Never Married 2 X Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yes,	ECENDENT OF NISPA specify Cuben, Mexic ES 2 NO Speci	an, Puerto Rica		Bie	CE — American Indien, ck, White, atc. city:	
	15. DECEDENT'S EI (Specify only highest gra		16a. DECEDENT'S	DENT'S USUAL OCCUPATION Inc. I 18b. KIND OF BUSINESS/INDUSTRY KIND OF BUSINESS/INDUSTRY NOT use retired.						
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	Teache			F	Educati	ion		
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA					
	Ermon W. Taylor				Matti					
	190. INFORMANT'S NAME (Type/Print) Walter F Coolin	g			end Number or Rurel Rd Chesaj				15	
	20a. METHOD OF DISPOSITION	20	N DI ACE DE DISDO	SCITION (Name of	amatan, amatan, ar			ION — City or		
	1 Deutel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIE CREMENT OF FUN								City MD	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSE /			Foard F		Home			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition									
	resulting in death)	a. <u>Dilativ</u>	e cardi	omyopa	thy				five	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										
CAL CE	PART II. Other algorificant conditi	ona contributing to death i	but not resulting	In the underly	ing cause given in	Part I. 24	Ia. WAS AN AUT	TOPSY 24	Ib. WERE AUTOPSY FINDINGS	
	Farctured hi	p-repaired	Massiv	e CVA	with le	ft 1	PERFORME		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	hemiplegia	atrial fib	rillati	on, Os	teoarth	<u>ri</u> tis			1 YES 2 NO	
	Severe Gasti		h bleed							
	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 DOA	OTHER:	PLACE OF DEATH (C		Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b, TI	ME OF 28c. I	NJURY AT WORK? YES 2 NO	T	IBE HOW INJU	RY OCCURED		
- 10	3 Suicide 8 Could not t 4 Homicide determined		Y — At home, farm, polify)	, street, factory, of	fice		ON (Street and Town, State)	Number or Rure	I Route Number,	
COMPLEIED	onel	YSICIAN: To the best of my know INER: On the basis of examination							e(e) end manner as stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIF	Wollow	Olevek	esen me	-91		25	d. DATE SIGNE	ED (Month, Day, Year)	
	Wallace Obensh 30. NAME AND ADDRESS OF PERSON		EATN (ITEM 27) (To	on, Print)	D-071	29		Apr	14. 1995	
	Wallace Obensh									
ļ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE	114 11/4	-3					
	APR1 8 1995	Juli Davidson R	ardall							



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the host	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		iMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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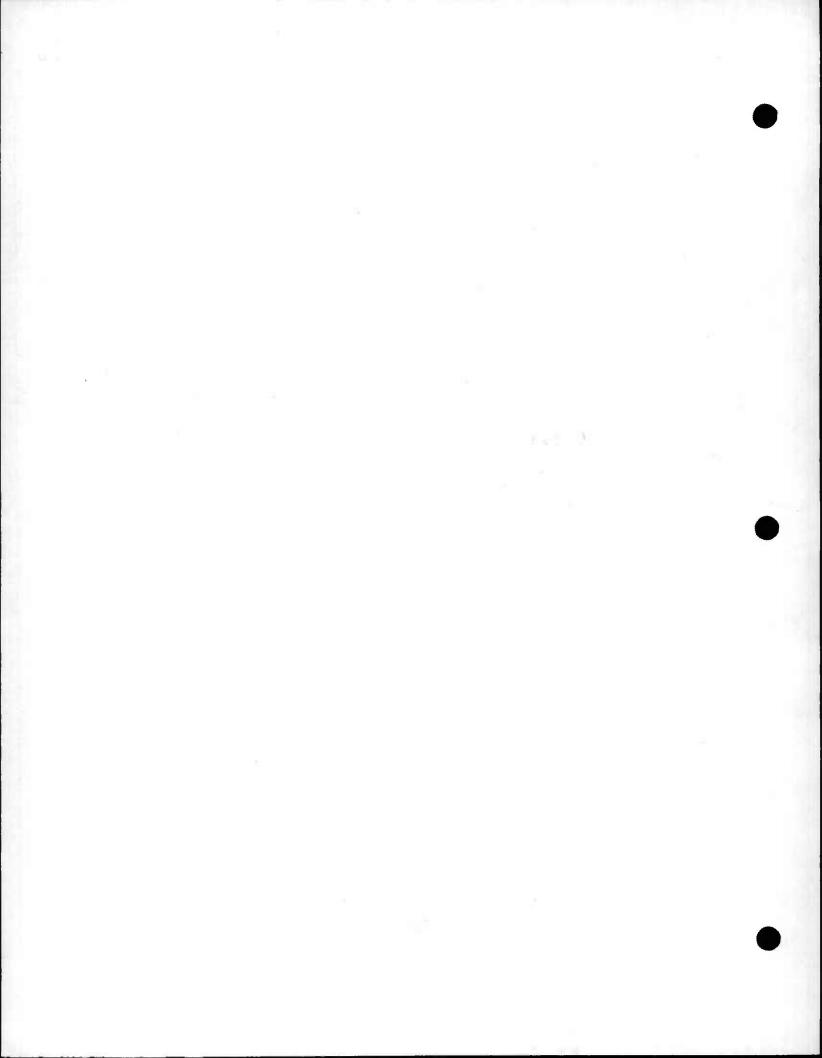
Richard S. 4

31. DATE FILED (MONTH, Day, Year)
APR 1 2

											9	5	13713
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMEN	T OF H	IEALTH DEAT	AND I	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
1	Carolyn 7	Trump C1	ark						MONT		005	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. let	et histodesi	E INDE	R 1 YEAR	IF UNDER	04 1000		OF BIRTH	1993		3:50 P. M
		1 M 2 F			MONTHS	T	HOURS	MIN.	(Mont)	h, Day, Year)		8. BIRTH	PLACE (State or Foreign y)
	199-07-3308		73	YRS.					May	2, 192	21	Penn	sylvania
	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
6	12 Park Lane					Е	1ktor	า			Cec	il	
DIRECTOR	RESIDENCE OF DECEDENT												
12	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
0	Maryland	Cecil			E	1kto	n						1 YES 2 T NO
A	10e. STREET AND NUMBER					101	. ZIP COOE				10g. CIT	IZEN OF W	WHAT COUNTRY?
FUNERAL	12 Park Lane						21	1921			II.	4 +	Chahaa
Z	11. MARITAL STATUS	12. WAS DECEDEN	T EVED IN U.S. AE	OMEO	140	WH C 050				17 (Specify Yes			States
	1 Never Married 2 Married	FORCES? 1	YES 2 X		- 1	If yes, sp	ecify Cuba	n, Mexical	n, Puerto I	er (Specify tes Ricen, atc.)	or No-	14. RACE Black	— American Indian, c, White, etc.
₩	3 Wildowed 4 Olvorced	IF YES, GIVE V	AR OR DATES			1 TYES	2 🔯 NO	Specify	/ :			Speci	⊮ White
0	15. DECEOENT'S EDU	CATION	14n DE	ECEDENT'S	HOUAL C	OCCUPATION OF			1				
	(Specify only highest grade	completed)	(G	ive kind of Do NOT u	work done	during mo	st of workin	g	16b	. KIND OF BUS	INESS/INI	DUSTRY	
📛	Elementary/Secondary (0-12)	College (1-4 or 5	,										
\ \frac{8}{2} \rightarrow	12		H	omem	aker]	Her Ow	n Hor	ne	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAI	ME (First, I	Middle, Maiden	Surname)		
BE	Admiral Trump						Pea	arl Y	Yost				
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a				ber, City or Town	n, State, Zip	Code)	
2	Stanley E. Clark	c. Sr.	1							on, MD			
	20a. METHOD OF DISPOSITION		20b. PLACE					C , 1		E 20c. LO			wo State
	1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cometany cre	amaton, or o	ther place	1		1					Maryland
	21. SIGNATURE OF UNERAL SERVICE U	MENSEE)	INOLLII	Eas	Me	NAME AN	IST (em.	4/.	IZINOT	cn Ea	ast,	Maryland
	11/0000	11/			7	Crou	ch Fu	inera	al Ho	ome			
	Vocal 1		ous		1:	27 S	outh	Mair	n Sti	reet,	North	n Eas	st Md 21901
	23. PART I. Enter the diseases, Dr o	omplications that	t coused the de	ath. Do i									Approximats
	snock, or neart issure.	List only one cau	se on each line).							,		Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	T	7.7 1	2 1			- 1						Onset and Death
	resulting in death)	. Inter DUE TO	Shiral	141	MONE	217	Tibre	2515					
		DOE 10	(OH AS A CONSE	OUENCE O	h):	/							
CERTIFICATION	Sequentially list conditions.	b											
Ė	if sny, lesding to immediate cause. Enter UNDERLYING	DUE 10	(OR AS A CONSE	OUENCE O	F):								
걸	CAUSE (Disease or Injury	C											
는	thet initiated events resulting in deeth) LAST	DUE TO	(OR AS A CONSE	QUENCE O	7):								
H	resulting in deeth) LAST	d											
	PART II. Other significent condition	e contribution to	dooth but not a		- 44-		00.00			10000			
PHYSICIAN: MEDICAL	The second condition	contributing to	deeth but not r	eauiting	n (ne u	nderiying	ceuse g	iven in i	Part I.	24a, WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
ă									_	1 TES 2	NO NO		COMPLETION OF CAUSE OF DEATH?
E I													1 YES 2 NO
ä	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO 🗵	UNC	ERTAIN					
N N	25. WAS CASE REFERRED TO MEDICAL			E OF OEAT									
8	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ noa	OTHE		- >						
¥	27. MANNER OF DEATH	28a, DATE OF		28b. TIM		28c, INJI	DV AT	Hdence (CRIBE HOW IN	HIPV OO	CHEED	
	1 X Natural 5 Pending	(Month, D			URY	WO	RK?		200. DE3	CHIBE HOW IF	JURY OCI	CORED	
BY	2 Accident Investigation	201 81 405 0	F IN II I I I I				ES 2 _	NO					
	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At ho atc. (Specify)	me, tarm, :	treet, fac	tory, office			28f. LOCA	ATION (Street a or Town, State)	nd Number	or Rural R	oute Number,
COMPLETED	(Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occum	d at the t	lime, date	and place,	and due	to the cau	se(s) and man	ner as stat	ed.	
2	one) 2 MEDICAL EXAMINE												and manner as stated.
	296. SIGNATHIE AND FITTE OF CERTIFIER			-									
H	RDZ	TAN					29c. LICE		_	- 1			(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	A COMPLETED					U 3	005	5 5		- 4	-11-	75
4 10	THE PERSON WHEN THE PERSON WHEN	U SUMPLETED CALLS	E OF DEATH ATEL	M 27) /Tmo	Delegal								

Ackart MD. III High ST. Shite 103

ElkTun, MO 21921-5565

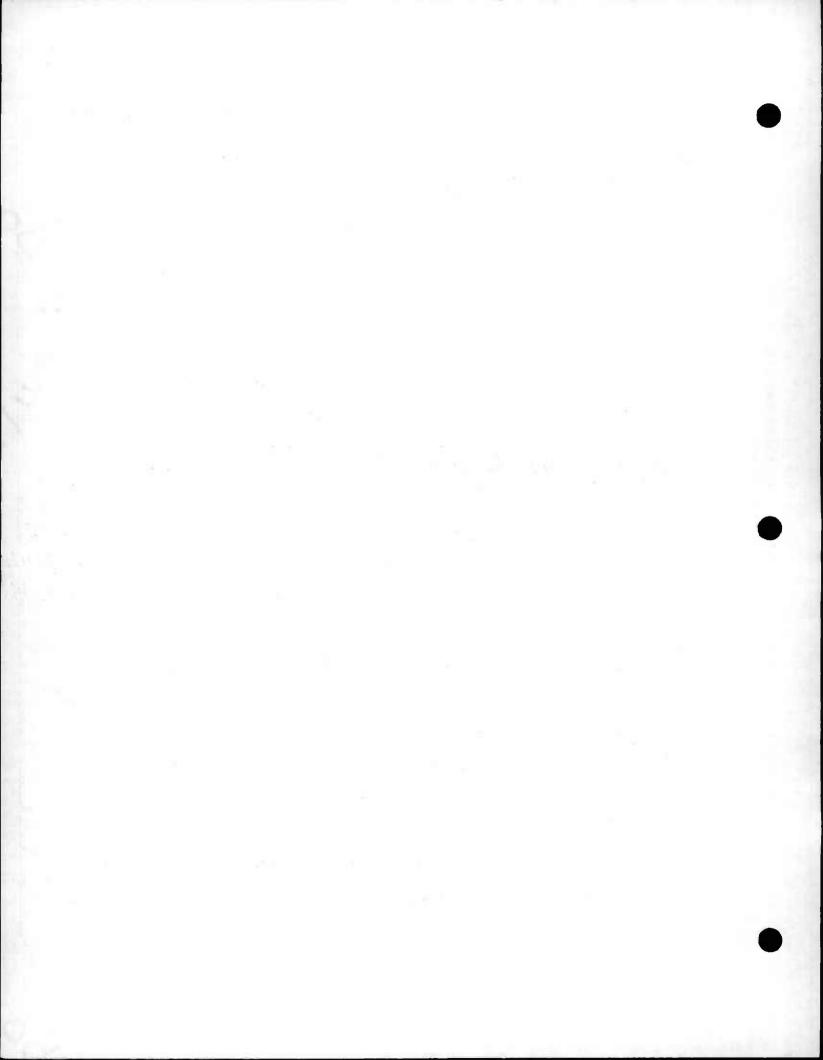


DALLINONE, MANTLAND	nours after death. Page 6 may be retained by the hos	d in by the funeral director, page 5 should be detache or removal.	medical examiner must be notified at once.	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

					95	13714				
	1 - STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF HEALTH AN	ID MENTAL HYGIE						
	1. OECEDENT'S NAME (First, Middle, Last) John Edward	Cl	hesley	2. DATE OF DEATH	9 1995A	3. TIME OF DEATH 6:34 A				
	217-18-2269 1 7	(In yrs. lest birthday) 5 YRS.	IF UNDER 1 YEAR IF UNDER 24 HOURS M	rs. 7. DATE OF BIRTH (Month, Day, Year) FEB. 14	(Month, Day, Year) Country)					
OR .	98. FACILITY NAME (If not institution, give street end number) Physicians Memorial Ho	spital	9b. CITY, TOWN OR LOCATION O	OF DEATH	eath 9c. county of Di Charle					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c, CIT	Y, TOWN OR LOCATION			10d. INSIDE CITY				
	MARYLAND CHARLES	MARS	SHALL'S CORNER			LIMITS?				
FUNERAL	#7750 HAWTHORNE ROAD		10f. ZIP CODE 20646		10g. CITIZEN OF V					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 N YES	2 NO	13. WAS DECENDENT OF H If yes, specify Cuban, M 1 YES 2XXNO S	exican, Puerto Rican, etc.)	ANIC ORIGIN? (Specify Yaa or No— 14. RACE Black, Puarto Rican, etc.)					
豆	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of w	USUAL OCCUPATION rork done during most of working	16b. KINO OF B	USINESS/INDUSTRY	BLACK				
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 6TH GRADE	MECHA	,	ATITON	10BILES	h h				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	11120111		S NAME (First, Middle, Maide						
띪	BERNARD SYLVESTER CHESLEY 190. INFORMANT'S NAME (Type/Print)	TOP WATERIO		RE WADE HILI						
2	LLOYD E. CHESLEY		ADDRESS (Street and Number or F PIN OAK STREE'							
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State	b. PLACE AND DATE O	F DISPOSITION (Name of	OATE 20c I	OCATION - City or	Town State				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	T. JOSEPH	S CHURCH CEM 22. NAME AND ADDRESS C THORNTON FU	4/21/95 PC	OMFRET, N	MARYLAND				
	LIDIA C. THORNTON JOHNSON	M00583	3439 LIVING	NERAL HOME, STON ROAD,]	P.A. INDIAN HE	EAD, MD. 20640				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SEPSIS 24 NR									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): A Z O TEM A DUE TO (OR AS A CONSEQUENCE OF): A Z O TEM A DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
H	resulting in death) LAST									
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death	RRYTH	n the underlying cause given		RMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?				
	DID TOBACCO USE CONTRIBUTE TO CAUSE O	DE DEATH YE	S NO UNCER	TAIN [7]		1 PES 2 NO				
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEAT	H (Check only one)	All4 L		MAT				
IX	1 YES 2 NO 1 Inputant 2 ER/Out		OTHER: 4 Nursing Home 5 Reside	nce 6 Other (Specify) 26d. DESCRIBE HOW						
ВУ Р	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Netural 5 Pending (Month, Day, Year) INJURY WORK?								
ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, st	A A	261. LOCATION (Street City or Town, State	and Number or Rure	al Route Number,				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of axamination					e(a) and manner on stated.				
BE	29b. SIGNATURE AND TITLE OF CONTIFER	, , , , , , , , , , , , , , , , , , , ,	29c. LICENSE D-444		29d. DATE SIGN	(Month, Der, Year)				
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DI Ashvinkumar Patel, Md 603	Post Of	fice Road S	uite 207 V	Waldorf	, MD20602				

32. ARGISTRANS SIGNATURE
Jaha daudior Randall

APR 1 9 1995



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Flours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
TTENDING	TOR: After after deal	28 is m
L OR AT	DIRECT hours a	item 2
THE HOSPITA	THE FUNERAL filed within 72	PORTANT: If
2	23	Ξ

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permit. Pages 1, 2, 3 should

95 13715 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Light A PS 2. DATE OF OEATH 3. TIME OF OEATH **1**995 CHARLES EDWARD COMPTON APRIL 8, 3:35P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 1/8/29 5 SEX 6. AGE (In yrs, last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 212-30-3329 66 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF OEATH DIRECTOR FORT HOWARD, MD. 21052 Fort Howard Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Monkton 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? York Road 16306 Old 2111 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puarto Rican, atc.)
 \(\subseteq \text{YE} \) NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married B 3 Widowed 4 Divorced Caucasian COMPLETED 15. OECEOENT'S EOUCATION (Specify only highest grade complete 18a. OECEOENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 2 Contractor Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hollyday Sothern Compton Elizabeth BE Griswold Phelps 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 02138 2 Phelps Compton Hollyday 26 Chauncey St. Cambridge. Mass. 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata arrol or other place) Cremation Hampstead. Marylan 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland 23. PART I. Enter the dieeeses, or complications that caused the deeth. Do not enter the mode of dying, euch as cardiec or reepiratory arrest, Approximate shock, or heert feilure. List only one ceuee on each line. intervel Between IMMEDIATE CAUSE (Finel Onset end Death disease or condition resulting in death) ALCOHOL ABUSE OUE TO (OR AS A CONSEQUENCE OF): **PNEUMONIA** CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate ceuse. Enter UNDERLYING SEPSIS CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events recuiting in deeth) LAST PART ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) ВУ COMPLETED

1 YES 2 NO	HOSPITAL: 1 Inpatient 2 □ ER/Outpatient 3	DOA 4 Nu	R: rsing Home 5 - Residence	6 Other (Specify)		
27. MANNER OF DEATH 1 Naturel 5 Pending 2 Accident Investigation 3 Suicida 8 Could not be 4 Homicide determined	28a. OATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. OEŞCRIBE HOW INJURY OCCUREO		
	28a. PLACE OF INJURY — At hor building, etc. (Specify)	ne, farm, atreat, fac	ctory, offica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
eoical Examine	P. On the besis of examination and/or in			is to the cause(s) and manner as stated. e fims, data and place, and due to the cause(s) and manner as stated.		
the management from your a confinement			1			

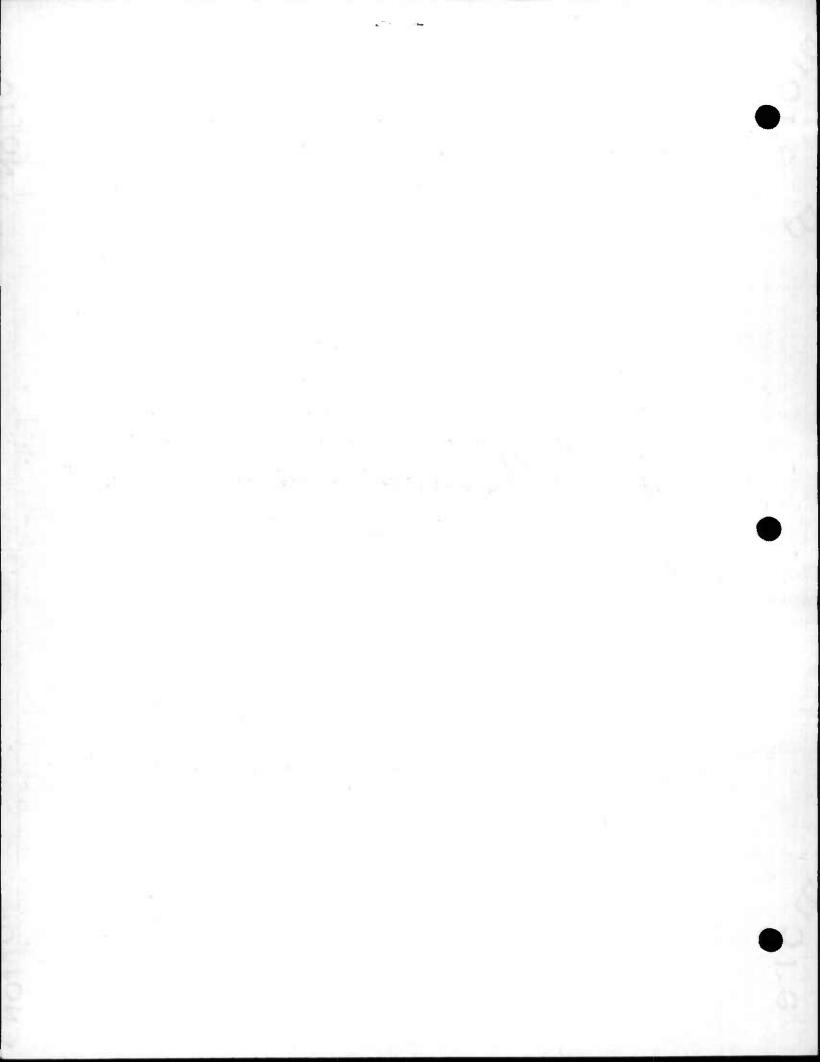
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RAUL RIVERA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052

31. DATE FILED (Month, Day, Year) 42. REGISTRAR'S SIGNATURE Davidson Res

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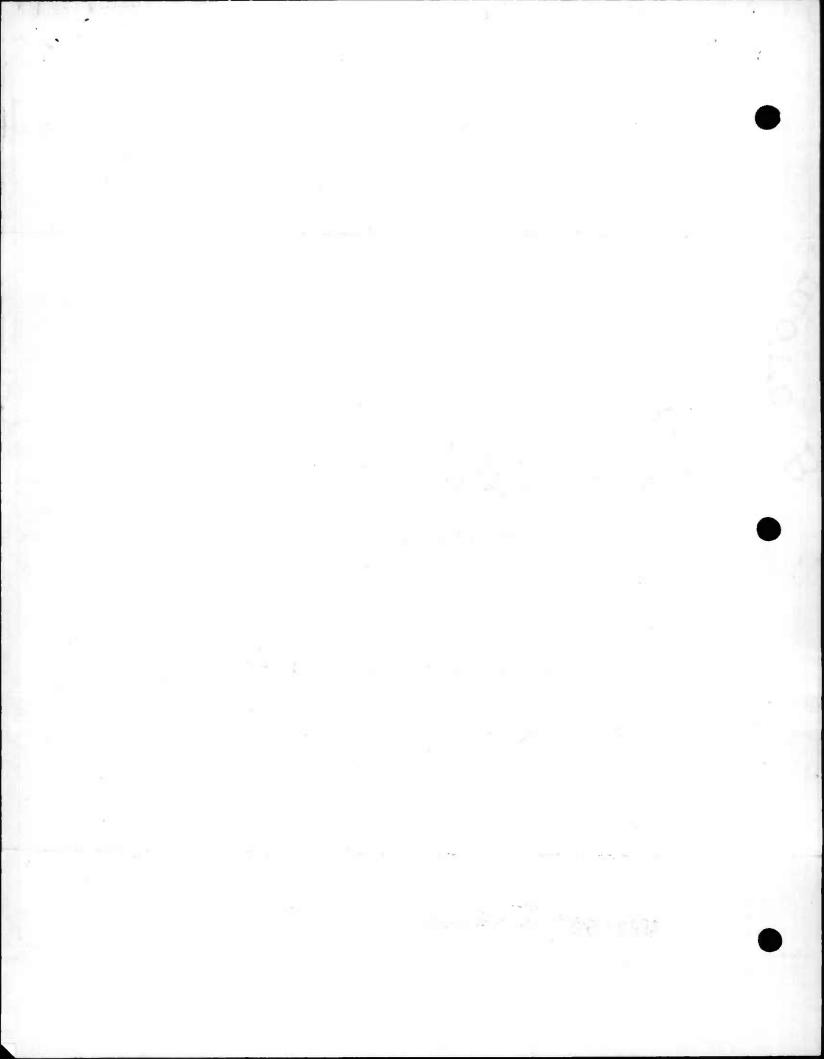
		500								95		3/16
		1 - STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	RTMENT OF	HEALTH	AND				
		1. DECEOENT'S NAME (First, Middle, Last)			RIIF	ICAIE O	r DEA	In .	REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH			
13		Jeffrey	Leo Ciemny						April 10 199			0135
-11		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. las		IF UNDER 1 YEAR		R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHE	LACE (State or Foreign
무		215-74-5110		38	YRS. MONTHS DAYS			MIN.	March 8,		Mar	yland
3 should	œ	90. FACILITY NAME (If not institution, give	·		96. CITY, TOWN OR LOCATION OF DEAT				ATH			
2, 2,	ECTOR	9528 Perryhall	Blvd. Apt	10	4	Per	ryha:	11			Balt:	more
sades	l H	10s. STATE 10s. COUNT	TY .		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?	
permit. Pages	- DIR	Maryland	Harford		Bel Air						1 ≥ YES 2 □ NO	
	FUNERAL	100. STREET AND NUMBER 820 Dora Place			10f. ZIP CODE 21014				10g. CITIZE			HAT COUNTRY?
020 physician. bunal-transit	1 8	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARI	MED	13 WAS D			HC OBICING (Secole)	V N-	USA	
020 physician bunial-trar		1 Never Married 2 Married	FORCES? 1 YES	2X N	2X NO If yes, specify Cuben, Mexicer			en, Puerto Ricen, etc.)		Black, Specify	- American Indian, White, etc.	
21215-0020 al or attending physic for use as the burial	D BY	3 Wildowed 4 Divorced					77	9,000,1				White
o aft	ETE	15. DECEDENT'S EDI (Specify only highest grad	e completed)	(Gi	CEDENT'S ve kind of a Do NOT us	USUAL OCCUPATION dork done during in	TION most of worki	ng	16b. KINO OF BUSIN		INES8/INDUSTRY	
O g g		Elementary/Secondary (0-12)	College (1-4 or 5 +) 4			1 Techn	olovi	a+		Medi	1	
LAND the hospite e detached t once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	-	110	arca.	I ICCILI	_		ME (First, Middle, Maid		Cal	
- 60 m	Lin		Ciemny				Ca	ther	ine Adel	la G	razia	no
MAR retained 5 should	0	19a. INFORMANT'S NAME (Type/Print)							Route Number, City or 1		ip Code)	
m, og å 🕏		Susan J. Ciemny						el A	ir, Md. 2			
E iii		1 Donation 5 Other (Special	noval from State 20b	etery, crer	metory or of	OF DISPOSITION (I					City or Tow	
Page al dire		21. MONATURE OF FUNERAL SERVICE OF		. A.	ren	CIS & CO	AND AODRE	SS OF FA	CILITY		ter,	
ALTIN death Pay toward of examiner		1/4 / k		-	1	Howa	rd K.	McC	omas III	Funer	al Ho	me, P.A.
Our after d is by the or removal	П	23. PART I. Enter the diseases, or	complications that caused	the de	th. Do n	not enter the m	ode of dy	lna, such	y St., Be	Diretory a	, Ma.	21014
		IMMEDIATE CAUSE (Final Onset and De									Interval Between Onset and Death	
etely fill, emation, it, the		disesse or condition resulting in death)	· lutraore	P	9 lm	Not h	Jones	P				
DUE TO (OR AS A CONSEQUENCE OF):												
OX 68 e be execut sician and c infor to burit traumatic	CATION	Sequentially list conditions, if sny, leading to immediate	b DUE TO (OR AS A	CONSEO	UENCE OF	F):						
ste be ysiciar prior trau	CAT	cause. Enter UNDERLYING CAUSE (Disesse or Injury	c,									İ
certificate ding physical sygiene profile of the certificate profile of the certificate o		that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQ	UENCE OF	7:						
	CERTIFI		d		-							
		PART II. Other significant condition	ns contributing to desth b	ut not re	suiting i	in the underlyl	ng cause	given in	Part I. 24a. WAS /	N AUTOPSY		VERE AUTOPSY FINDINGS
IN RECORDS faw requires that the as been signed by the pept, of Health and M 23 shows any inje	MEDICA								1 1/	2 NO		WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
w requires been sign x. of Healt										YES 2 NO		
AL Ne law has be Dept.	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				S NO [ERTAIN	1 🗆 📗		-	
N: The ficate State	SICI	EXAMINER? 1 XYES 2 NO	HOSPITAL:			OTHER:			8 XOther (Specify) &	a+ cc	iono	
HYSICIA his certif with the	PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		26b, TIMI	E OF 28c. IN	JURY AT	sidence	28d. OESCRIBE HOW			•
ONG PHYS After this death with	87	1 Natural 5 Pending 2 Accident Investigation	Found4/9/95	-	235	UHA 10	YES 2	NO	s. Lintslot sett			
ENDIN AT THE GE IS I	E	3 Suroide 6 Could not be	280. PLACE OF INJURY building, atc. (Spec	my)	0 1	treet, factory, off	cn	,	281. LOCATION (Street City or Town, Sta	(0)	r or Rural Ro	ute Number, Aporto
OR ATTENDING OR ECTOR: After hours after death item 28 is ma		M. CERTIFIER		ves		ice			9528 Pa	my He	1 Dew	evend 104
(Check only Check on Check only Check on Ch							Ford County					
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	8	MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the couse(a) and manner as stated.									inti milimati ne stated.	
THE fled	BE	296. SIGNATURE AND TITLE OF CERTIFIE	0, 1	0	29c. LICENSE NUM							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)							.M.E.	A	pril	10 1995		
		THEODORE M.K		111			eet	Rai	ltimore	Marri	land	21201
		31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGN	ATUSE					CTHOLE	Hary	<u> rand</u>	61201
		APR 1 2 1995	Jalia davelson	Mark	14							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacibled for use as the burial-trans BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

APR 2 8 1995

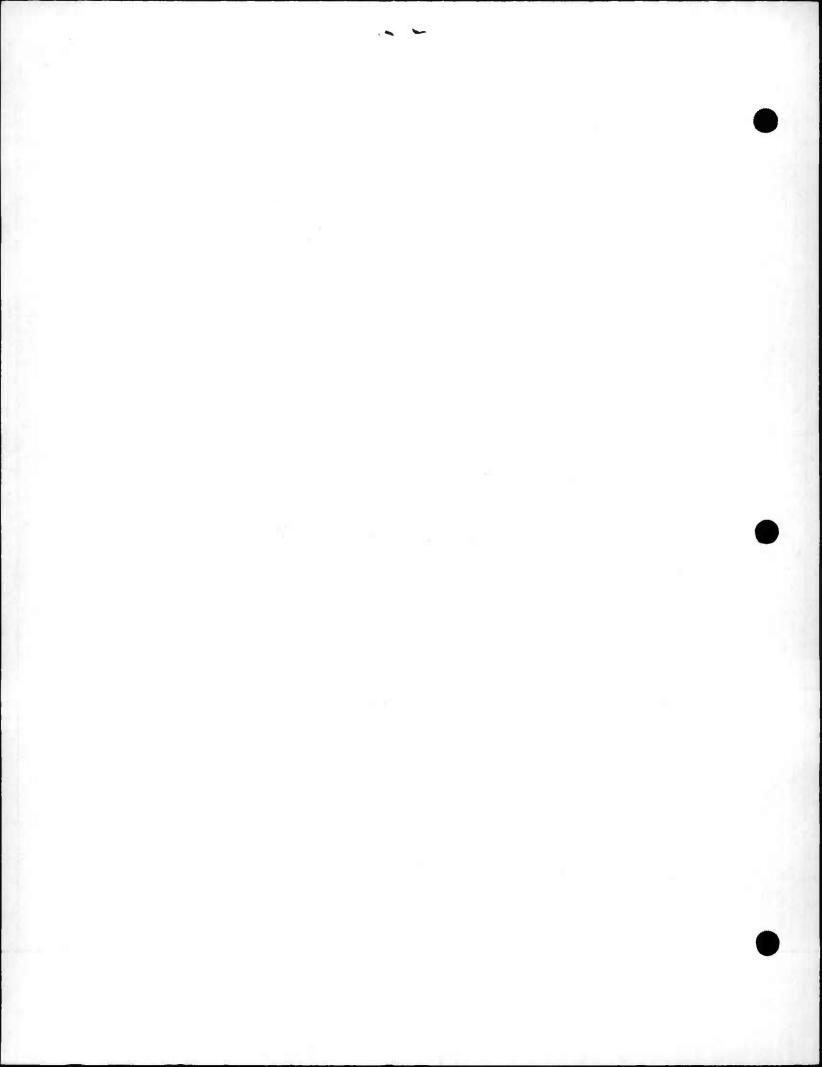
							95	13/17
	FOR 1 - STATE REGISTRAR	STATE OF MARY	AND / DEPAR	RTMENT O	F HEALTH AND I	MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)				J. BLAIII	2. DATE OF OEATN		3. TIME OF DEATH
	CON-PABLO	CARREO	N-KNABLE			APRIL 18		8:55 a M
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	# UNDER 1 YE		7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
	NONE	1 🔀 M 2 🗆 F	YRS.	MONTHS DA	YS HOURS MIN.	(Month, Day, Year) March 1, 1	005	Country)
	9e. FACILITY NAME (If not institution, give s	treet end number)			WN OR LOCATION OF DE		9c. COUNTY	
5	THE JOHNS HOPKINS	HOSPITAL		BALTI	MORE CITY			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	1	10c. CIT	Y. TOWN OR L	OCATION			List Million Comm
뜸	MD Washi	ngton						10d. INSIOE CITY LIMITS?
	10e. STREET AND NUMBER	HSTOIL		lancock	101. ZIP CODE		10g. CITIZEN	1 YES 2 NO
FUNERAL	8707 Corner Road				21750		USA	
15	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS	DECENDENT OF HISPAN	HC ORIGIN? (Specify Yes		RACE - American Indian.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES		II yes	i, specify Cuben, Mexice YES 2 📝 NO — Specify	n, Puerto Ricen, etc.)		Black, White, etc. Specify:
8								White
ETE	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e, DECEDENT'S (Give kind of life, Do NOT us	work done during	PATION g most of working	16b. KINO OF BU	SINESS/INDUST	TRY
	Elementary/Secondary (0-12)	College (1-4 or 5+)				NO	NE	
once. COMPL	17. FATNER'S NAME (First, Middle, Last)		Non	ie	40 MOTHERIC NA	ME (First, Middle, Maiden	_	
E O	Dale Eugene Knabl	A				analili Ca:		
B B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	net and Number or Rural F			riel
	Dale E. Knable				RD Hancocl			00)
20	20e. METHOO OF DISPOSITION 1 \(\bar{\Delta} \) Burial 2 \(\bar{\Delta} \) Cremelion 3 \(\bar{\Delta} \) Rem		D. PLACE AND OATE	OF DISPOSITION				or Town, State
must	4 Donetion 5 Other (Specify)		netery, cremetory or o chard Ri	dee Ce	em. 4/20/	/95 Hane	cock, I	MD
examiner	21. SICHATURE OF FUNERAL SERVICE LE	ZINGE O			e AND ADDRESS OF FAC		300113	
еха	Licer	2 Ota	1000		Box 368 H		217	50
medical	23. PART I. Entar the diseases, or other than the second self-up to the second self-up t	omplications that ceuse	d tha deeth. Do r					
	shock, or haart failure. IMMEDIATE CAUSE (Finel	List only one cause on e	ach line.					Interval Between Onsat and Death
후	disease or condition resulting in death)	Necunti	77.00	Enter	or pittis			
event, the	resulting in death)	DUE TO (OR AS)	CONSEQUENCE OF	F):				24hours
	Commented to the condition	Extrem	e Pr	emat	rivity			48days
or other traumatic	If any, leading to immediate	DUE TO (OR AS	CONSEQUENCE OF	F):	J			
P 5	CAUSE (Disease or injury	·						
a E	that initieted events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ጉ :				
CER		1						
In In	PART II. Other significent condition	s contributing to deeth b	out not resulting i	n the underl	ying ceuse given in	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINOINGS
shows any inj : MEDICAL	DIC, SEPSIS	, INTRAVER	MIRICULA	R HE	MORRHAG	E PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME							70	OF DEATH?
e Z	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YE	S INO	UNCERTAIN	<u></u>		
Item 2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HORBITAL	28. PLACE OF DEAT		one)			
or It	1 TES 2 TO	1) Inpetient 2 ER/Out	patient 3 DOA	OTHER: 4 Nursing I	Nome 5 Residence	6 Other (Specify)		
- T	27. MANNER OF DEATN 1 Netural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c.	INJURY AT WORK?	28d. DESCRIBE NOW II	JURY OCCUR	EO
marked BY PI	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s city)	treet, factory, o	office	28f. LOCATION (Street a City or Town, State)	nd Number or R	lural Route Number,
ЕШ								
If ite		CIAN: To the best of my know						
CON	2 MEDICAL EXAMINE	R: On the besie of examination	n end/or investigatio	n, in my opinio	n, death occured at the l	lime, date end piece, and	d due to the ca	use(e) end manner ee stated.
토 교	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE \$10	GNED (Month, Day, Year)
INPO B	Beitha Kaony			LOW	M8	424	Apr	11 18, 1995
-	30. NAME AND AGORESS OF PERSON WHO	COMPLETEO CAUSE OF OE			0. 0		V	
	21 DATE FILED ALCOND	MSC #210	600 N	MOL	.FE ST P	SAUTIM OF	E MC	21205
1 1	31. DATE FILED (Month, Day, Year)	JAR. PROJETHAR'S SHOW	a de la					



1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Middle, Last)	TC					MONTH	DF DEATH DAY	1005 YEA	R	OF DEATH
	5. SEX	6. AGE (In yrs. last	birthday) I	F UNDER 1 YEA	R IF UNDER 24 HRS.	-				
	1 🗌 M 2 🌠 F	77		· · ·		(Month.	Day, Year)	C	ountry)	state or roreign
stitution, give st	reet and number)		9	b. CITY, TOW	N OR LOCATION OF D					
	MORIAL H	OSPITAL		OAI	KLAND			GAR	RETT	
10b. COUNTY			10c, CITY, 1	OWN OR LO	CATION				10d. INS	IOE CITY
G.	ARRETT		OA	KLAND						ITS?
					101. ZIP COOE			10g. CITIZEN	F WHAT COL	JNTRY?
N STRE										
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rced	IF YES, GIVE V	MAR OR GATES		יםי [ES 2 [A] NO Specif	fy:		s	pecify: WHI	TE
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-12)	College (1-4 or 5	+) life.	Do NOT use n	etired.)			OWN HO	ME		
iddle, Last)		11011	LIME	IX.	18 MOTHED'S NA					
os Jo	HNSON, S	R.								
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al .	Com	physics &		Acco	dubt.				On	set and Daa
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diata	DUE TO	(OR AS A CONSEQ	UENCE OF):							
	DUE TO	(OR AS A CONSEO	UENCE OF):							
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nt condition:	contributing to	death but not re	eulting in	the underly	ing cause given in	Part I	24- 450 414	UZOBEY	Odb WEDE AL	TODOU CHINA
			southing in	ana unuany	mig cause givan m	rait i.	PERFORM	EO?	AVAILABL	E PRIOR TO TION OF CAUSE
						_	1 YES 2	Д ио	DF DEAT	
O USE	CONTRIBUT	E TO CAU	SE OF	DEATH	YES NO					3 1 110
MEDICAL	HOSPITAL :		To		PLACE OF DEATH (Ch	eck only one				
	1 X Inpatient 2		DOA 4	Muraing 19	The state of the s	6 🖂 Other	(Specify)			
Pending	28a, DATE OF (Month, D	INJURY		Y	WORK?	28d. DESC	RIBE HOW INJ	JURY OCCURED	8	
	28e. PLACE O	F INJURY At hon	ne, farm, stre		St. Education of the Contract	28f. LOCA	TION /Street an	d Number or flu	rai făruda Munt	fini:
	building,	C. (Specify)				City o	Town, State)	P. 518119000 000 1700	M. () (400) (100)	
FYING PHYSIC	TAN: To she pleat of	my knowledge, dea	th occurred i	if the time, d	ata and place, and due	to the caus	e(s) and mann	or as stated		
									ee(s) and man	mer as stated.
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	NTY ME SECURITY 10b. COUNTY G. N STRE. Merried Proced SECURITY EDUCY Phylosic grade 10 S JO STRE Merried SECURITY EDUCY Phylosic grade SECURITY EDUCY SECURITY SECURITY EDUCY	S. SEX 1 M 2 F Institution, give street and number) NTY MEMORIAL H SEDENT 10b. COUNTY GARRETT N STREET 12. WAS DECEDED FORCES? IF YES, GIVE I CECENT'S EDUCATION In highest grade completed) D-12) College (1-4 or 5 College (1-	SER 5. SEX 6. AGE (In yrs. last 77 75 75 75 75 75 75 7	S. SEX 1	SER S. SEX 1	S. SEX	SEED AVIS SEEN S. SEX 1	BERN S. SEX S. AGE (in yrs. last behindary) SUBCEST YEAR FUNCES 3 HOSE. TO AGE OF SETTING 20 y Hose SETTING 20 y Hos	E DAVIS S. SEX	E DAVIS S. SEX S. ACE (in yrs. last brinding) PURCET 1741 FURCET S INTERNATION TO MATE A SEX TO WAS A COUNTY OF SERVEY AND TO WAS A COUNTY OF S



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nous after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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N.	Ficate	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	He
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	1 - STATE REGISTRAR		STATE OF I	MARYLAND) / DEPAI CERTIF	RTMENT FICAT	T OF H	IEALTH DEA	AND I	MENT	AL HYGIE!			
	1. DECEDENT'S NAME (First,	Middle, Last) IELEN	LOUIS							2. DAT MON AT	E OF DEATH		995	3. TIME OF DEATH 3:45
	4. SOCIAL SECURITY NUMBER 214-07-96		5. SEX	6. AGE (In yrs. 94		IF UNDE	DAYS	IF UNDER	24 HRS. MIN.	7. DAT	E OF BIRTH		8. BIRTI	HPLACE (State or Foreign
œ	9a. FACILITY NAME (If not ins		treet end number) Genera	1 Hogs				rid				9c. COU	NTY OF D	DEATH
DIRECTOR	RESIDENCE OF DEC			1 1105					ge			1)(orci	nester
	Maryland		rchester		10c. Cl	Cai	nbri							10d. INSIDE CITY LIMITS? 1 TY YES 2 NO
FUNERAL	100. STREET AND NUMBER 317 Mil	lı St.					101	zip cod	• 1613				J.S.Z	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 1 XX Widowed 4 Divor		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2000 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- II yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. RACE — American Indier Bleck, White, etc. 15. YES 2000 Specify: White, etc. 16. Specify: White, etc.											
COMPLETED	15. DECE (Specify only Elementary/Secondary (0-	highest grade	CATION completed) College (1-4 or 5		Give kind of life. Do NOT	S USUAL C work done use retired.)	CCUPATIO during mo	ON asl of working	ng	16	b. KIND OF BU	ISINESS/INI	DUSTRY	
MPL	11 17. FATHER'S NAME (First, Mic			,	hom	emak	er							
BE CC	Tv.	Villia	m S. Canı	non					I	ula	Middle, Maide Condo	n		
70		Marian C. Dail 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 317 Mill St., Cambridge Md. 21613												
	20a. METHOD OF DISPOSITION 5 Burlet 2 Cremation 4 Donation 5 Other	Cremation 3 Removal from State complex, gremators of other place!												
	21. SIGNATURE OF FUNERAL		ENSEE		w.z.z.wg	22.	NAME AN	as Fu	ss of fac	al H				
	23. PART V Enter the disease pr condition resulting in death)	ert fellure.	Cong	t caused the las on each i	_{ine.} Heart	: Fai			ing, euch	h sa ca	rdiec Dr reap	iratory en	rest,	Approximeta intervel Between Onset and Death days
CERTIFICATION	Sequentially list condition if any, leeding to immed ceuse. Enter UNDERLYING CAUSE (Disease or Injurthat Initiated evente resulting in deeth) LAST	liete NG Ty	Arte DUE TO	rioscl (or as a con	erotic seouence c	Car	diov	ascu	lar	Dis	ease			years
_	PART II. Other significer Pneumonia		e contributing to	death but no	ot resulting	in the u	nderiyinç	g cauee (given in I	Part I.	24a. WAS AI PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ME	Severe Rhe					_		1 1014		· Pro		7		1 TYES 2 NO
PHYSICIAN: MEDICA	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		LACE OF DEA	TH (Check	only one)	UNC	ERTAIN	A IXI			_	
IVSI	1 YES 2 NO		1) Inpetient 2 28e. DATE OF		3 DOA 28b. TIN				eldence		er (Specify)			
BY PI	1 Natural 5 P	Pending Investigation	(Month, D	lay, Year)		JURY M	WO	RK?] NO	28a. DE	SCRIBE HOW	INJUHY OC	CURED	
		Could not be letermined	28s. PLACE O building,	F INJURY — At etc. (Specify)	homa, Jerm,	street, fac	lory, offici			281. LO	CATION (Street y or Town, State	end Number }	or Rural I	Route Number,
COMPLETED			CIAN: To the best of R: On the basis of a											e) and menner se stated.
TO BE C	29b. SIGNATURE AND TITLE	Tuk	with	7	nx	8		190c. LICI	WWW.	IBER	73	29d. OAT	PLL	(Month, Day, Year)
	Hubert L. I		M.D.	503	Byrn		et	Ca	mbri	.dge	, MD	2161	.3	
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31. DATE FILEO (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

9 1995

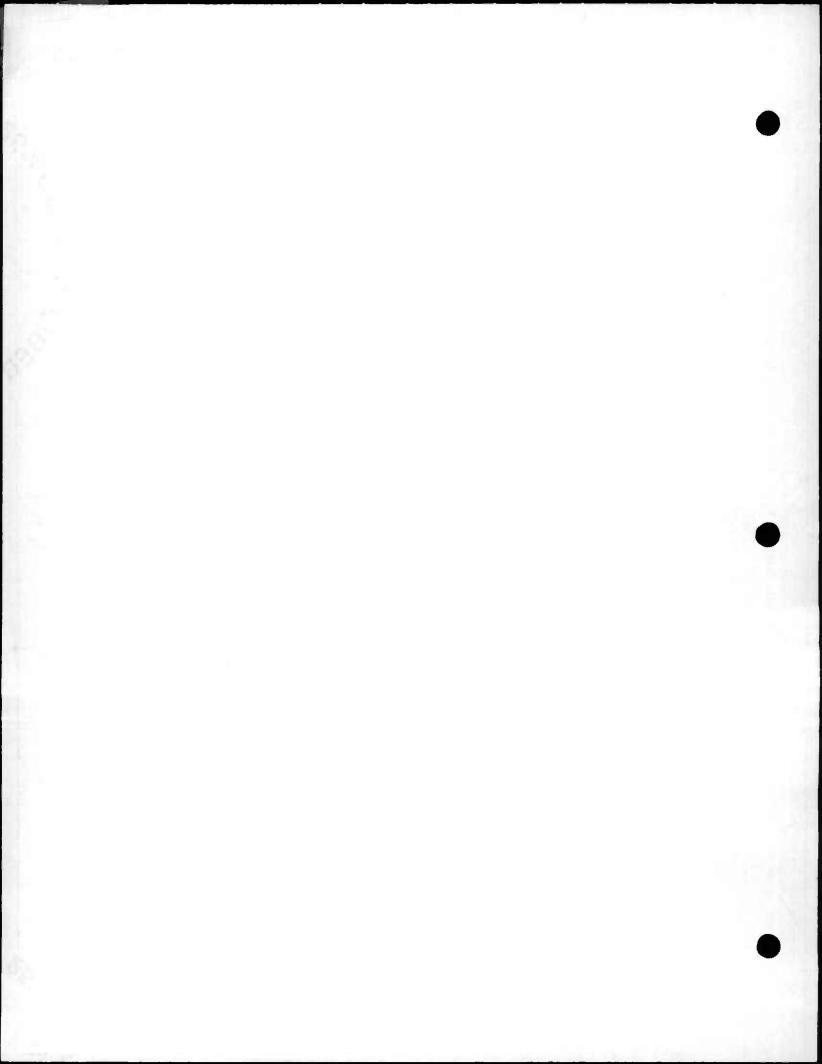
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Davidson Ren

Pages 1, 2, 3 should permit. funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. Ħ notified 24 hours after death. Page 6 may be filled in by the funeral director, page 9 ion, or removal. 9 must examiner medicai ysician and completely filled in prior to burlal, cremation, or the traumatic event, executed within signed by the attending physician Health and Mental Hygiene prior to certificate be other 6 that the death Injury. shows any requires has been SW Dept. 23 The Item r this certificate h PHYSICIAN: the 0 marked, L DIRECTOR: After the bours after death w ATTENDING 90 28 Item HOSPITAL OR TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 220 MONTH DARLING ELEN 4. SOCIAL SECURITY NUMBER 6. AGE (in vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
July 3, IF UNDER 1 YEAR IF UNDER 24 HRS 85 1 M 2 X I DAYS HOURS Virginia 264-52-0544 VRS 19099a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Randolph Hills Nursing Home Silver Spring Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 15201 Elkridge Way #1-C 20906 USA WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 H was asselfy Cuban, Mexican, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Bleck, White, atc. 1 Never Married 2 Married 8 1 YES 2 NO Specify: Specify: White 3 XWidowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEMENT'S FOLICATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 6 Clerk U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas H. Johnson Mary B. Harris BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 15201 Elkridge Way #1-C Silver Spring, MD Evelyn I. Johnson 20906 20a. METHOD OF DISPOSITION 1 🕮 Burial 2 🗆 Cremation 3 🗆 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State · Mary's Cemetery 4/18/95 4 Donation 5 Other (Specify) Washington, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. Leven 500 University Blvd.W. Sil.Spr.MD 20901 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heert fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Death myorcelial infarction disease or condition Tucks dag resulting in death) OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Mursing Home 5 Residence 8 Other (Specify) 1 | YES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 -Hatural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of symmetrion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

FARRAGUT AVE KENSINGTO

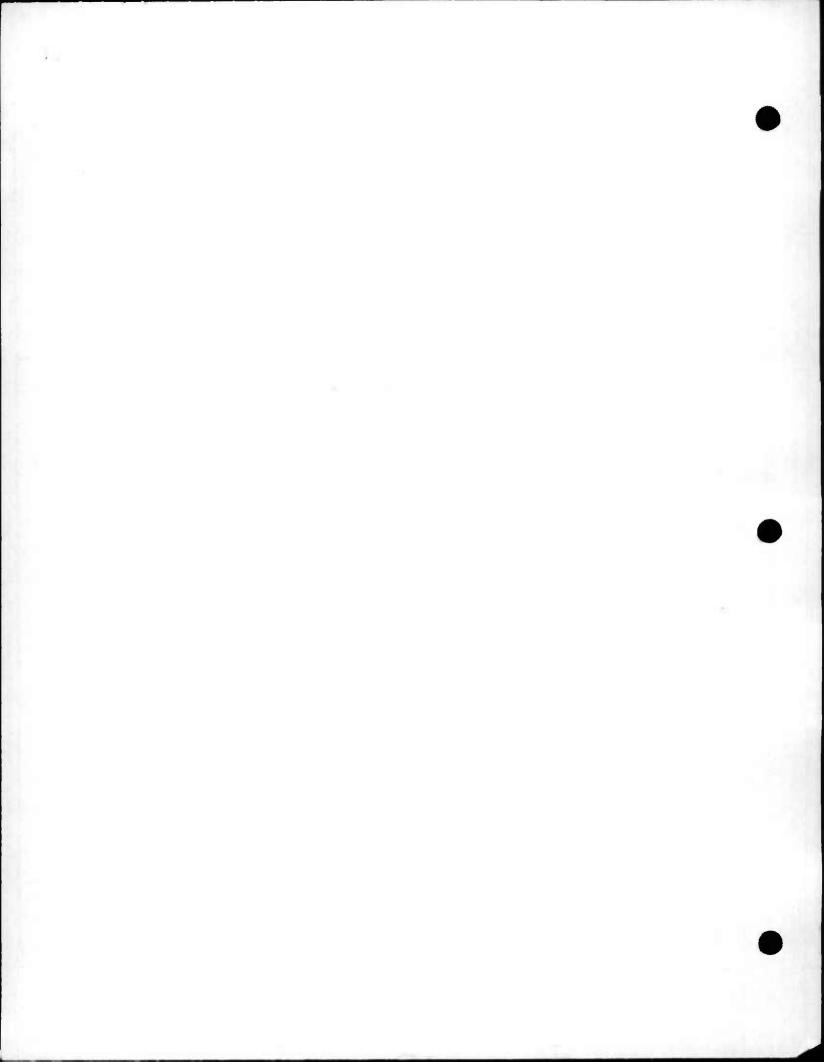


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART CERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY	4510	3. TIME OF DEATH
	Joan	Marie	Dur	n		APRIL 17	YEAR 1995	10:30 A.M
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Coun	HPLACE (State or Foreign
	577-36-5491 9a. FACILITY NAME (If not institution, give sti	1 M 2 X F	04 YAS.			May 7, 193	0 Was	hington, DC
Œ	9316 Edmonston R				R LOCATION OF DE	EATH	9c. COUNTY OF	
5	RESIDENCE OF DECEDENT	u., "101		Greenb	elt		Prince	e Georges
E	10a. STATE 10b. COUNTY			TOWN OR LOCAT	ION			10d. INSIDE CITY
0	Maryland Pri	nce Georges	Gre	enbelt				1 📉 YES 2 🗌 NO
RA	9316 Edmonston R	oad #101			ZIP CODE			WHAT COUNTRY?
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED		.0770	HC ORIGIN? (Specify Yes o	USA	
	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes, spe	city Cuban, Maxica 2 NO Specify	n, Puerto Rican, etc.)	Blac	E — American Indian, ck, White, etc.
ЭВУ	3 Widowed 4 Divorced				2 gg NO Specify	,.	Spec	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U	rk done during mos	N st of working	16b. KIND OF BUSIN	ESS/INDUSTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	Thetrus		Assistan	Carada.	1 17 1	
MO	17. FATHER'S NAME (First, Middle, Last)		Institut	cionai		nt Specia. ME (First, Middle, Melden St		cion
BE C	William Wallace	Hughes				et Opal The		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street ar		Route Number, City or Town,		
F	Kevin P. Dunn		1703	Wickham	Way Cr	ofton, MD	21114	
	20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	val from State ce	b. PLACE AND DATE OF	DISPOSITION (Name place)	me of	DATE 20c. LOCA	TION — City or T	own, Stata
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		ate of Hea		netery 4,	/20/95 Silv	er Spri	ng, MD
	+ House A Ct	-0		Franci	s J. Col	lins Funera		
	23. PART i. Enter the diseases, or co	omplications that ceuse	d the death. Do no	anter the mor	te of dving such	Blvd.W. S:	LI.Spr.	
	shock, or heart fellure. L	ist only one cause on	each ilne.	antor the more	or dynig, addi	i as caldiac of respira	tory arreat,	Approximate interval Batween
	disease or condition resulting in death)	Superior V	lena Cava	Syndrom	ie			Onset and Death
ĺ	resulting in death)		A CONSEQUENCE OF):		 			
Z	Sequentially list conditions,	Metastatio		Cell L	ung Canc	er		8 mos.
ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF):					1
SE	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF:					
CERTIFICATION	resulting in death) LAST	1						
	PART II. Other significant conditions	contribution to death	heet most resulting in	the restriction	anne about to t	I		
CAL	The state of the s	contributing to beautiful	out not resulting in	the underlying	cause given in i	Part I. 24s. WAS AN AL PERFORMI		MERE AUTOPSY FINDINGS AMULABLE PRIOR TO
MEDI						1 □ YES 2 2	E NO	OF DEATH?
2	DID TOBACCO USE CONTR	BUTE TO CAUSE O	OF DEATH YES	⊠ NO □	LINCEPTAIN	-		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTERNITAL			
ğ	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Out	petient 3 DOA 4	THER: Nursing Home	s X Residence	6 [] Other (Specify)		
E	27. MANNER OF DEATH 1 X Natural 5 7 Pending	28s. DATE OF INJURY (Month, Day, Year)	28h. TIME (OF 26c. INJU		384. DESCRIBE HOW INJ	URY OCCURED	
₩ I	2 Accident Investigation			1 77	E5 2 NO			
ED TED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	F — At home, farm, stre city)	et, factory, office	8	28f. LOCATION (Street and City or Rwn, State)	Number or Rurel I	Route Number
COMPLETE	29a. CERTIFIER 10X PHYSIC	IAN; To the great of my know	riedge, death occurred	of the time, date o	and place, and due	to the reveniet and manne	or an artered	
No.	MEDICAL BRAMINER	On the seats of examination	m and/or investigation,	in my opinion, de	ath occured at the I	time, clark and place, and o	due to the cause):	s) and menner as stated.
E C	296. SHANDING AND TITLE OF CERTIFIES	/	0		29c. LICENSE NUM		interest to make	(Morth, Day, Year)
∞	1000 M	11111111			D08754	0		19, 1995
임	30 NAME AND ADDRESS OF PERSON WHO				8 90			
J.	Thomas A. Bensinge			ay Cent	er Dr.Su	ite 205 Gr	eenbelt	, MD 20770
	APR 20 1995	Prima d'author	ADJRE CANDALL					
	7111 00 1000							

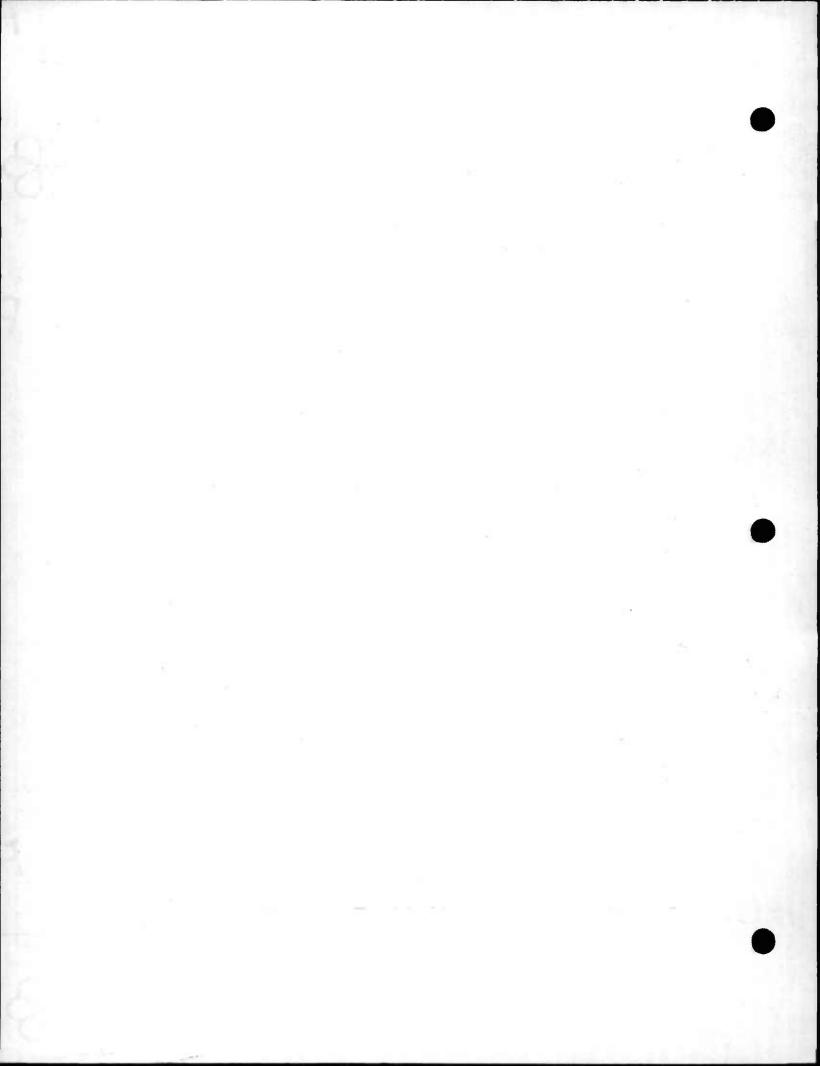


DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 DECEMENTS NAME (FILE)	Added to and			CENTIF	IOAIL	- 01		•	REG.		_	
	1. DECEDENT'S NAME (First Beverly Br	Activities and	avis							2. DATE OF DEAT	DAY	YEAR	5:05 P.
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	last hirthday)	IF UNDER	1 VEAR	IF UNDER	24 MBC	April 7. DATE OF BIRTI		1995	HPLACE (State or Foreig
	220-34-4258	2	1 M 2 TF	56	YRS.	MONTHS	DAYS	HOURS	MIN.	Month, Day, Ve Dec 28	020	Coun	(nv)
⊩	9a. FACILITY NAME (If not in			50	11.00								Jersey
.	and the second			_ 4				DR LOCATIO	ON OF DE	ATH		UNTY OF	
₽	13110 Old F		ertown Ro	ad		BC	wie				Pr.	ince	George
	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN O	R LOCAT	TION					10d, INSIDE CITY
DIRECTOR	MD	Princ	e George	1		wie							LIMITS?
							101	I. ZIP CODE			100 0	TITEN OF	TTYES 2 NO
FUNERAL	13110 Old F	`letche	ertown Ro	ad				20720			Ü		WHAT COUNTRY?
5 h	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMEO	13. \	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN? (Speci	y Yee or No.	T 14 BAC	E — American Indian,
	1 Never Married 2		FORCES? 1 IF YES, GIVE V		XNO	1	f yes, sp		n, Mexice	n, Puarto Rican, etc		Blac	ck, White, atc.
- 11	3 Widowed 4 X Dive	orced	, 125, a.i.c.	SAIL OIL BAILES			TE3	2 DENO	Specify			Spec	white
		EDENT'S EDUC		16a.	DECEDENT'S	USUAL OC	CCUPATIO	DN		16b. KIND O	BUSINESS/I		
. I	Elementary/Secondary (0	ly highest grade 0-12)	College (1-4 or 5	P)	(Give kind of life. Do NOT us	work done o se retired.)	during mo	st of working	g				
COMPLET	12				Office	e Man	age	r		Space	Indus	stry	
5	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTH	ER'S NA	ME (First, Middle, M.			
ш	Meyer Brown	l .						Ber	tha	Walcoff			
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	AODRESS	(Street a			loute Number, City of	r Town, State,	Zip Code)	
2	Ilana Forsy	the								Bowie N			
	20a. METHOD OF DISPOSIT			20b. PLA	CE ANO OATE						c. LOCATION		own. State
	1 ☐ Buriel 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other	Sn 3 A Ramo	oval from Stata	Meno	rah G	other place)	15			4-18 R	ockyi i	110	MD
- 11-	21. SIGNATURE OF FUNERA	Contract Contract	THISTE	Tricito	ruii ot	22, [NAME AN	ND ADDRES	S OF FA	CILITY			
	V 1.2	0 0				I E	APR M			FUNERAL			
	23. PART I. Enter the d												MD 20852
CERTIFICATION	Sequantisity list conditions, leading to imme cause. Enter UNDERLY, CAUSE (Disease or injuthat initiated events resulting in death) LAS	ing iry	с	(OR AS A CON	1							ر 	Jes
MEDICAL	PART II. Other significa	int condition	s contributing to	death but no	ot resulting	in tha un	derlying	g cause g	Ivan In	PE	S AN AUTOPS REFORMED? ES 2 ZNO	Y 24	b. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
Ä	25. WAS CASE REFERRED T	O MEDICAL					26. PL	ACE OF OR	EATH /Chr	ack only one)			
PHYSICI	1 YES - NO	1	HOSPITAL:	ER/Outpatient	3 □ DOA	OTHER	1 :	h		6 Other (Specify			
<u> </u>	27. MANNER OF DEATH		26a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	- I	28d. DESCRIBE H		CCURED	
		Pending	(Month, D	lay, Year)	IN.	JURY M		ORK? YES 2	NO				
	a Destate	Investigation Could not be	28e. PLACE O	F INJURY — At	t home, term,	streat, facto	ory, offic			28t. LOCATION (S	treet and Numb	er or Rural	Route Number.
9		determined	building,	atc. (Specify)						City or Town,			
COMPLE			CIAN: To the best of a										s) and menner as state
J 11	296. SIGNATURE AND TITLE	OF CENTIFICA	10					29s. LICE	NSE NUN	men	29d. D	ATE SIQNE	D (Mpnth, Day, Year)
u III	~	(0)	X					08	61	99	•	411	2/9<
H				OF OF OFATUR	TEM 27) /3/00	Print)						/ 1 1	
H L	30. NAME AND AODRESS OF	F PERSON WH	O COMPLETEO CAU	SE OF DEATH (TI LINDO	i, comp	1		_	^			, ,
H L	30. NAME AND ADDRESS OF	111	O COMPLETEO CAU	> 16	57		Tor	ton	BL	12 Cn	offe	N	lar orland
TO BE	31. OATE FILED (MOTHER, Day,	N W	var wi	R'S SIGNATURE	57		rest	ton	BI	id Cr	जी ०	7	Jos of pro
TO BE	EmilyF	N W	var wi	> 16	57		rest	ton	BI	id Cr	जी	7	lar offer

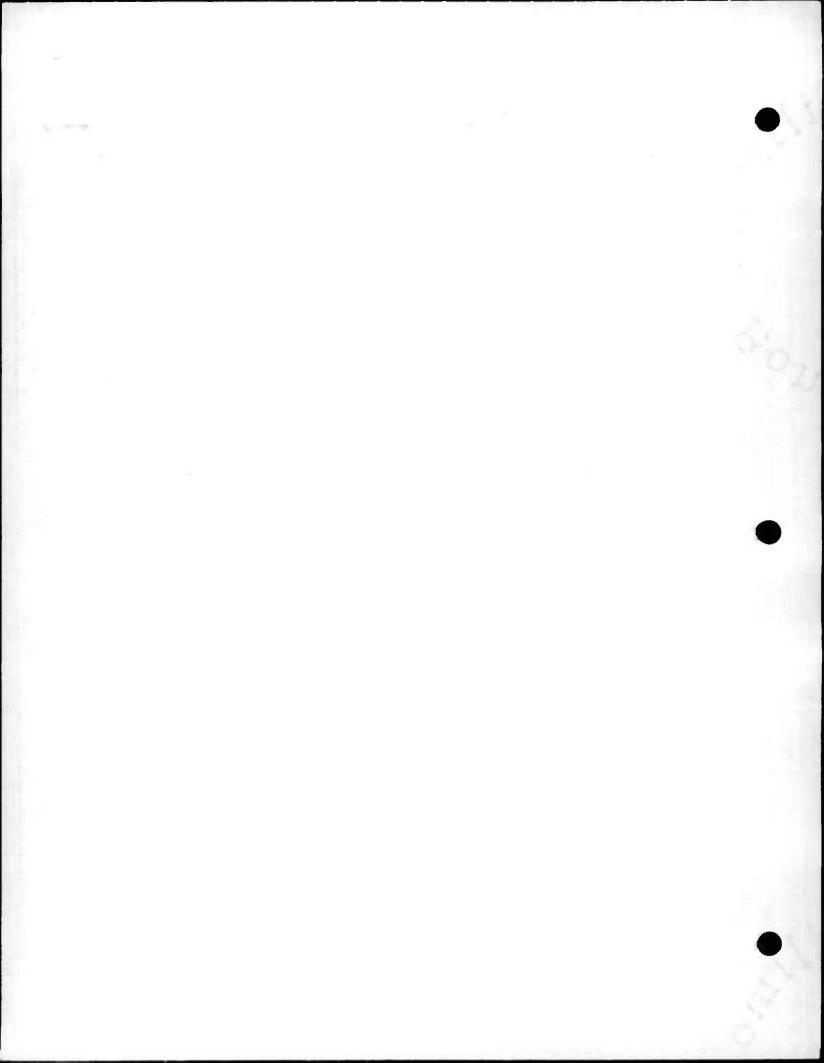


DIVISION OF VITAL RECORDS, P.O. BOX 68760

APR 21 1995

CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH April 19, 1995 06:15 A 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 8 AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year, DAYS HOURS 219-64-7111 1 X M 2 - F 40 YRS. Oct 26. 1954 Washington. should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH Pages 1, 2, 3 DIRECTOR Montgomery General Hospital Olney Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery **Brookville** 1 YES 2X NO permit. FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2600 Triadelphia Lake Road signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit Heatth and Mental Hygiens prior to burial, cremation, or removal. 20833 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black. White, etc. 1 X Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rice 1 ☐ YES 2 V NO Specify ¥ 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 1 Hairdresser Beauty Salon notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname, Edward Rizzo N. BE Joyce DeVinev 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Joyce N. Rizzo (Mother) Same as #10 be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must ! DATE 1 Buriel 2 X Cremetion 3 4 Donation 5 Other (Specify) netion 3 🗆 R Chesapeake Crematory

Chesapeake Crematory Beltsville, MD 4/20 examiner 21. SIGNATURE OF FUNERAL SERVICE LIGHNSEE 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Betv IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) neumonia TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): 200 Riciery Syndrone money CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 X NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL OTHER 1 YES 2 NO 1 Xinpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M BY 1 YES 2 NO 2 Accident 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide ETED. 8 Could not be 4 Homicide 29e. CERTIFIER COMPLI 1 (CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT	OF H	EALTH DEAT	AND N	MENTAL HYGI		ı		
	1. DECEDENT'S NAME (First, Middle, Leat) ORESSIE VIRG	INIA DAVI	S	-				2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH	м
	4. SOCIAL SECURITY NUMBER 214-09-5366	1 🗆 M 2 💢 F	E (In yrs. lest birthday) 81 yrs.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH		. BIRTHE	PLACE (State or Foreign	1
TOR	9a. FACILITY NAME (If not institution, give st WASHINGTON COL RESIDENCE OF DECEDENT		TAL			STO		ATH	9c. COUNT WAS		IG TON	
DIRECTOR	<u> </u>	SHINGTON		AGEF						10d. INSIDE CITY LIMITS? 1)\(\sum \) YES 2 \(\sum \) NO		
BY FUNERAL	7 EAST WASHIN				2	ZIP CODE 2174	0		U.	S.A	HAT COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 Tyes IF YES, GIVE WAR OR	3 2X NO	- 11	yes, spe	ENOENT OF	n, Mexican	IC ORIGIN? (Specify n, Puerto Ricen, etc.	Yes or No.— 1	4. RACE Black, Specify	American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EDU((Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	18a. DECEDENT'S (Give kind of life. Do NOT us COOK	work done d se retired.)	CUPATIO	N t of working	g		BUSINESS/INDU	STRY		
WO	17. FATHER'S NAME (First, Middle, Last)		1 0001			18. MOTH	IER'S NAM	AE (First, Middle, Mai				_
BE C		IVER NOF	RRIS				HAR			TEE	LE	
5	19a. INFORMANT'S NAME (Type/Print) CRAIG C. MIL	LER	331 SC	ADORESS OUTH	(Street en	on A	or Rural A VENU	Oute Number, City or E,HAGER	Town, State, Zip C STOWN,	MD.	21740	
	20a. METHOD OF DISPOSITION 1A. Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State	Db. PLACE AND DATE (ameterly, crematory or o EDAR LAWN	MEM(DRIA	L PAI	RK O	4-28-95	LOCATION — CH HAGERS	TOWN	rn, State N, MARYLA	NE
	· R. heel	Brady		Al 40	NDRE	ST AI	COF	FMAN FUN TAM ST	HAGERST	OWŃ.	INC. MD. 21740)
	23. PART i. Enter the diseases, or c shock, or heart failure. I	omplications that cause Liet only one cause on	ed the death. Do reach line.	not enter	the mod	e of dyir	ng, auch	as cerdiac or re	epiratory arres	ıt,	Approximata interval Between	en
	immediate cause (Final disease or condition resulting in death)	. Carl	A CONSEQUENCE OF	mo	nar	4	N	rest			6 Ray	eth
NOI	Sequentially list conditions,		A CONSEQUENCE OF	dest	2 0	In	far	ches)		-	
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):								
CER	resulting in death) LAST	J										
MEDICAL	PART II. Other algnificant conditions	e contributing to death	but not reaulting	n the und	derlying	ceuse gi	iven in F	PER	AN AUTOPSY FORMEO?		WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE	38
N: ME	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH YE	S 🗆 N	10 🗆	UNCE	ERTAIN		7		OF DEATH?	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check of								
1YS	1 VES 2-NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Out		4 🗆 Nursi	ng Home			Other (Specify)				
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M	26c. INJU WOR 1 YE	K?		28d. DESCRIBE HO	W INJURY OCCUI	RED		
ETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	IY — Al home, ferm, secify)	treet, facto	ry, office			28f. LOCATION (Str. City or Town, St	et and Number or ste)	Rural Ro	ute Number,	
COMPLETED	one) 2 MEDICAL EXAMINER	CIAN: To the best of my known									and manner as stated,	
TO BE	296. SIGNATURE INO TITLE OF CERTIFIER	ale	p.0	١	- 1	29c. LICEN	278	98	1 de	124	Month, Dey, Year)	
	30. NAME AND ADDRESS OF PERSON WHO FRANCESCO L , A	NDRADE.			ill.	57.	H	AGERS	TOWN	, /	MD	
	31. DATE FILED (Month, Day, Year) APR 2 7 199	32. REGISTRAR'S SIGN	NATURE PARLE	!								

MENTAL HYGIENE REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIRECTOR

FUNERAL

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COMPLETED

BE

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CERTIFICATION

MEDICAL

PHYSICIAN:

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TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If Item 21

once.

must

FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPAR CERTIF				
DECEDENT'S NAME (First, Middle, Last) Robert Francis	Dunn					
SOCIAL SECURITY NUMBER 105-14-0129	5. SEX	8. AGE (In yrs. lest birthday) 73 YRS.	IF UNDER	1 YEAR DAYS	IF UNDE	R 24 HRS.

2. DATE OF DEATH 3. TIME OF DEATH 8 BIRTHPLACE /S March 1,1922 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington County Hospital Hagerstown Washington RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Washington Hagerstown 1 TYES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 18620 Maugans Ave. 21742 U.S.A 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5 +) 12 Machinist Railroad 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Peter Francis Dunn Murtle Kitson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 187 U.S. Silica Berkeley Springs, WV. 25411 Robert L. Dunn 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Smithsburg Crematory 4-19-95 T 5 Other (Specify) Smithsburg, Md. 22. NAME AND ADDRESS OF FACILITY 12525 Bradbury Ave. tennes 1 Davis Funeral Home Smithsburg, Md. 21783 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Moz Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING Trachea CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 24a. WAS AN AUTOPSY 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🛱 UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatie 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. restigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) APR 2

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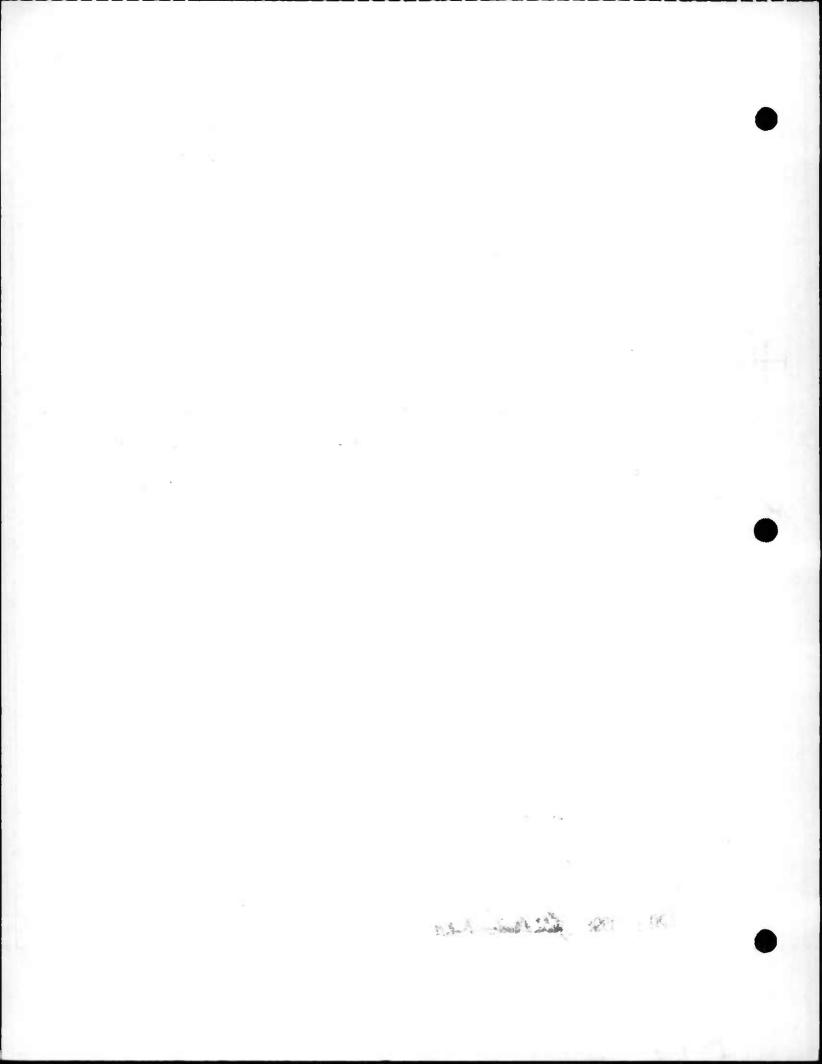
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DIVISION OF VITAL RECORD

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF I			T OF HEALTH		ENTAL HYGIENI REG. NO.	E			
1	1. DECEDENT'S NAME (First, Middle, Last) Nina DeLauter					2. DATE OF DEATH MONTH 15	1995 EAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER $220-16-1090 \hspace{1.5cm} \text{1} \hspace{0.5cm} \text{M} \hspace{0.5cm} \text{2} \hspace{0.5cm} \mathbb{X} \hspace{0.5cm} \text{F}$	20-16-1090 1 - M 2 X F 73 YRS. MONTHS DAYS HOURS MIN. Oct. 29, 1921 Mary								
10H	99. FACILITY NAME (If not institution, give street end number) 15629 Quirauk School Rd. RESIDENCE OF DECEDENT	9c. COUNTY OF	DEATH Ederick							
DIRECTOR	10a. STATE 10b. COUNTY Md. Frederick	ederick 180c. CITY, TOWN OR LOCATION Sabillas vil			ille		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
VERAL	100. STREET AND NUMBER 15629 Quirauk School Rd.							10g. CITIZEN OF WHAT COUNTRY? U.S.A		
BY FUNERAL	1 Never Married 2 X Merried FORCES?	1 Never Married 2 Merried FORCES? 1 YES 2 NO			OF HISPANII en, Mexican, Specify:	C ORIGIN? (Specify Yea Puarto Ricen, etc.)	В	ACE — American Indian, ack, White, etc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondery (0-12) College (1-4 or 5 +) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of work					18b. KIND OF BUS	Home			
BE CON	17. FATHER'S NAME (First, Middle, Leat) RUSSELL II. Lewis				Halli	E (First, Middle, Melden : e Tyler				
10	190. INFORMANT'S NAME (Typo/Print) Howard L. DeLauter Sr.	19b.	MAILING ADDRES 5629 QU	is (Street and Number Mauk Sc	r or Aurel Ac hool	nute Number, City or Town Rd. Sabill	, State, Zip Code) Las VIII (2,Md. 21780		
	20e. METHOO OF DISPOSITION 1 Surfel 2 Cremetton 3 Removal hurs than 4 Open for 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	206. PLACE AN COMMENTAL SECTION OF THE COMMENT OF T	22	ery 4-18	SE OF FACI	Caso	cation - chy or cade, Md.			
	7	wo	D	avis Fun	eral	Home Smith	isburg, N	dd. 21783		
	23. PART I. Enter the diseasea, or complications the ehock, or heert fellure. Liet only one can immediate CAUSE (Finel disease or condition resulting in deeth)	coused the deal use on each line.	0-				atory arrest,	Approximate intervel Between Onaet and Death 7 MON S		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST b. OUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other eignificent conditione contributing to	death but not re-	sulting in the u	nderlying ceuse	given in P	PERFORI	MED?	4b. WERE AUTOPSY FINDINGS AWAIL ABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
	DID TOBACCO USE CONTRIBUTE TO CA				ERTAIN			1 TES 2 NO		
PHYSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	OF OEATH (Check OT HE 4 No	R:	aeldence 6	☐ Other (Specify)				
BY PH	27. MANNEB-OF DEATH Natural 5 Pending Accident Investigation		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2		28d. DESCRIBE HOW IN	JURY OCCURED			
3 Suicida 6 Could not be 4 Homicide detarmined 28a. PLACE OF INJURY — At home, lerm, street, lactory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, lerm, street, lactory, office City or Town, State)								l Route Number,		
COMPLE	29e. CERTIFIER (Check only 2 MEDICAL EXAMINER: On the beet of one)							s(e) end menner ee steted.		
2 2 2	296. SIGNATURE AND TITLE OF CERTIFIER	not M.	D. Ph	. D. D	ENSE NUMB	9 I	29d. DATE SIGN	17/95		
_	-36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU . 1799 HOWELL Rd	Hager	27) (Typo, Print) STOWY	1 Mo	12	1740 60	orge'lr	KWMAN MD		
	"APR" 10 (70 1995") Selic De. REDISTRA	SIGNATURE								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

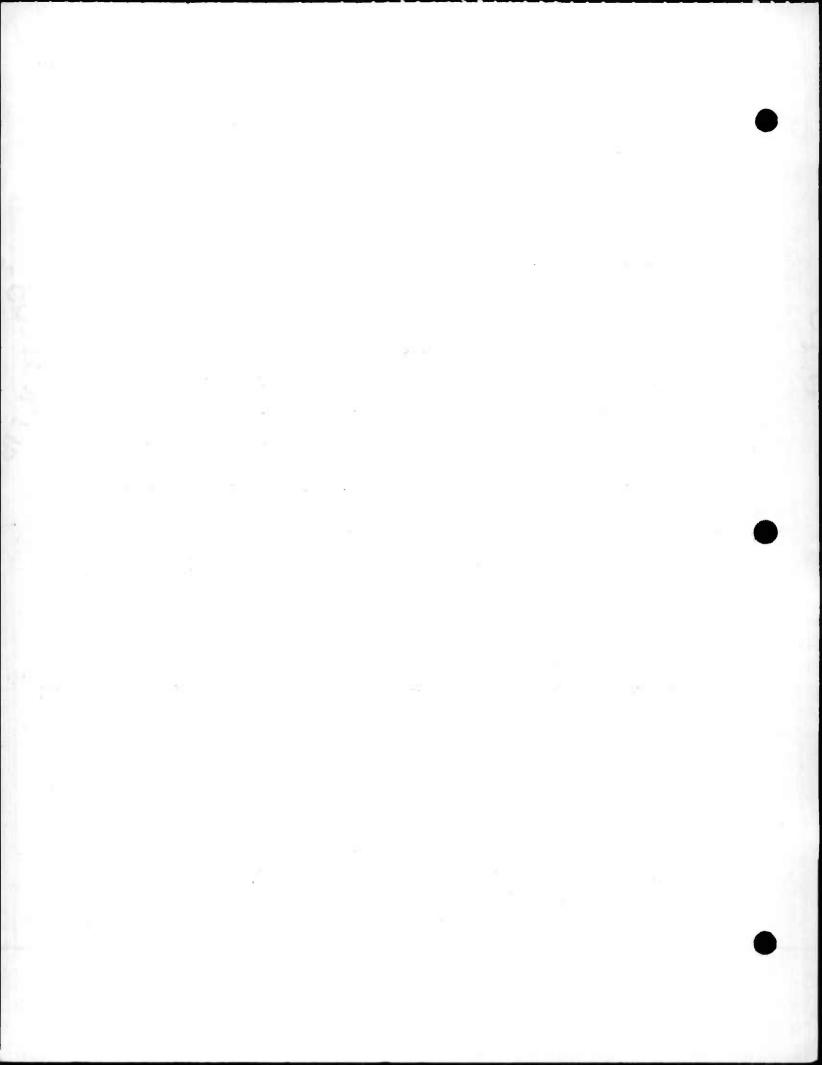
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

	1 - STATE REGISTRAR	CERTIF	ICATE OF	DEATH	REG	NO				
	DECEDENT'S NAME (First, Middle, Lest) MARY	F. DORSEY			2. DATE OF DEA MONTH APRIL 15	TN DAY	YEAR	3. TIME OF DEATH		
1	214-38-8267 1 □ M 2 🖫 F	AGE (In yrs. lest birthdey) 90 YRS,	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye OCT. 1	N par)	Counti	HPLACE (State or Foreign ny) YLAND		
TOR	9a. FACILITY NAME (If not institution, give street and number) 2 STEPHAINE LANE RESIDENCE OF DECEDENT		9b. CITY, TOWN	OR LOCATION OF D	DEATN		UNTY OF D ANNE	ARUNDEL		
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND ANNE ARUNDEL		TY, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS? 11 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 2 STEPHANINE LANE		101. ZIP CODE 21403				10g. CITIZEN OF WHAT COUL			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAF	YES 2 NO	If yes, sp	ENDENT OF NISPA ecity Cuban, Maxic 2 NO Spec	NIC ORIGIN? (Speci ear, Puarto Rican, et ily:	ly Yas or No	14. RACE Black Speci BLA	E — American Indian, k, White, atc. //y: CK		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 t.h	16a. DECEDENT'S (Give kind of life. Do NOT of HOMEMAK		ON ost of working	16b, KIND O	F BUSINESS/IN	·			
COM	17. FATNER'S NAME (First, Middle, Last) ALFRED ROSS				AME (First, Middle, M					
TO BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street a		Route Number, City of	r Town, State, Z	ip Code)			
F	IRENE DORSEY				NAPOLIS,					
	20a. METHOD OF DISPOSITION DATE 20b. PLACE AND DATE OF DISPOSITION (Name of completely grandlers) 20c. LOCATION — City or Town, Stata 4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, Stata 4/20/95 DRURY, MD.									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ACILITY MORTUARY, ANNAPOLIS		2140	1		
	23. PART I. Enter the diseases, or complications that c	aused the death. Do						Approximata Interval Batween		
	ahock, 6r heart tailure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to log as a consequence on:									
ATION	Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
DICAL	PART II. Other significant conditions contributing to de		- Administra	g cauae given ir	PE	S AN AUTOPSY REORMED? ES 2 NO	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?		
: ME	DID TOBACCO USE CONTRIBUTE TO CAU			1 LINCEPTAL				1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		TH (Check only one)	ONCERIA						
KSI	1 YES 2 NO 1 Inpetient 2 E	R/Outpatient 3 DOA			8 Other (Specify					
BY PH	27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigation 28a. DATE OF IN (Month, Day.		JURY WO	URY AT PRK? YES 2 NO	28d. DEŞCRIBE H	OW INJURY OC	CURED			
	2 Accident 3 Suicide 6 Could not be determined 4 Nomicide Nomicide Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my one) 2 MEDICAL EXAMINER: On the basis of exam							i) and manner as stated.		
BE	298 SIGNATURE AND STILE OF CENTIFIER	R		LICENSE NU				(Morem Day Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CANSE	OF DEATH WEN STATION	m) (But	She Go	De la	21	+01		
	APR 1 8 1995	SIGNATURE)	/		0					

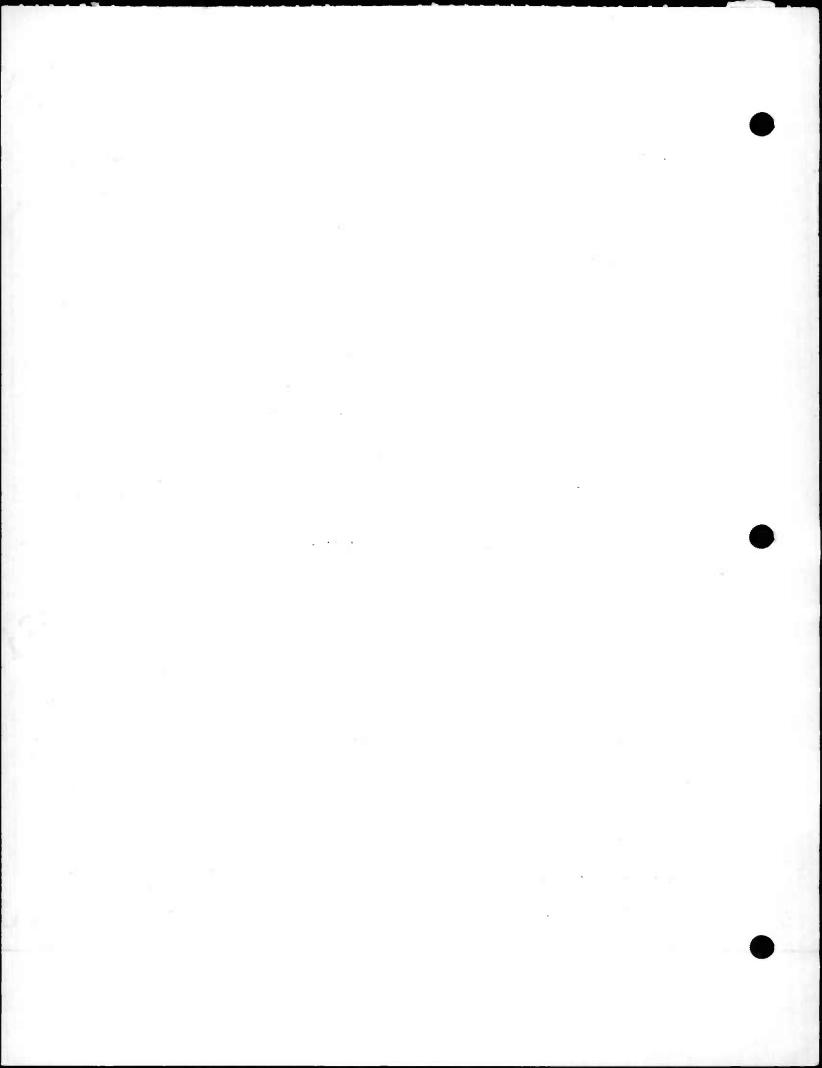


DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR AITENDING PHYSICIAN: The law requires that the death certificate be executed within The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely

hours after death. Page 6 may be retained by the hospital or attending physician. Bed in by the funeral director, nage 5 should be detached for use as the bunal-trans

Lillian Education A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) A SOULA SCOUNT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES (Part NAMES AND CONTROLL) B SOURT NAMES AND CONTROLL (Part NAMES AND CONTROLL) B SOURT NAMES AND CONTROLL (Part NAMES AND CONTROLL) B SOURT NAMES AND CONTROLL (Part NAMES AND CONTROLL) B SOURT NAMES AND CONTROLL (Part NAMES AND CONTROLL (Part NAMES AND CONTROLL) B SOURT NAMES AND CONTROLL (Part NAMES AND CONTROL		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF HEALTH		TAL HYGIEN REG. NO.	E	
4 SOCIAL SECURITY NUMBERS 1		,				2. D/	ATE OF DEATH		
Be AMCLITY MANE (If or de namellos), per usage and unanew) HERDERNSE OF DECERBENY MONTGOMERY MONTGO		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)		R 24 HRS. 7, DA	TE OF BIRTH	8.80	RTHPLACE (State or Formige
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Section of Description 1.801 Rockville Pike	Ä								
18.01 ROCKVIILE PIKE 1 MAN DECEMBER OF MARKING DIRECTORY IN SECURITY OF MARKING DIRECTORY IN SEC		10e. STREET AND NUMBER				DE		10g. CITIZEN O	
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TO BE THE PROPERTY OF THE PROP	TED								
DAY THE COTING The Normal Continue of the	PLE		College (1-4 or 5+)	Ille. Do NOT us	e retired.)		Candy		
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Sequentially its conditions and the initiated areas are life in the initiate areas are life in the initiated areas are life in the initiated areas areas are life in the initiate areas are li	TO B								
23. PART I. Entar the diseases, be-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10	2			D. PLACE AND DATE (F DISPOSITION (Name of				
23. PART I. Entar tha diseases, be-complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10	Ē	4 Donetion 5 Other (Specify)	/ M			4-	-20 Flus	shing N	7
23. PART II. Entar tha disease, be-complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NOTIFIED TO THE CAUSE (Final disease or condition resulting in death) NOTIFIED TO THE CAUSE (Final disease or condition) Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): Cause Enter INDERIVING CAUSE (Disease or injury to the death of the cause) DUE TO (OR AS A CONSEQUENCE OF): Cause Enter INDERIVING CAUSE (Disease or injury to the death of the cause) DUE TO (OR AS A CONSEQUENCE OF): Cause Enter INDERIVING CAUSE (Disease or injury to the death of the cause) DUE TO (OR AS A CONSEQUENCE OF): Cause Enter INDERIVING CAUSE (Disease or injury to the death of the cause) DUE TO (OR AS A CONSEQUENCE OF): Cause Enter INDERIVING CAUSE (Disease or injury to the death of the cause) DUE TO (OR AS A CONSEQUENCE OF): Cause Enter Index available to the cause of the conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART	examine	21. SIGNATURE OF FUNERAL SERVICE	MCENSEE		Edward Sag	gel Fune			MD 20052
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DEVELOPMENT OF DEATH SAMINER? O								. /	COMPLETION DF CAUSE
29e. CERTIFIER (Check only MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee atsted. 29e. CERTIFIER (Check only MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner ee atsted. 29e. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Yell of CERTIFIER) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON, GIZI MONTROSE ROAD ROCKVILLE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	show	DID TOBACCO USE CON	ITRIBUTE TO CAUSE C	DE DEATH YE	S D NO D UNIO	CEDTAIN	'		1 - YES 2 NO
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29e. CERTIFIER (Check only MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee atsted. 29e. CERTIFIER (Check only MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee atsted. 29e. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Yell of the cause) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 33. PAGESTRAR'S SIGNATURE	narked,	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME	JRY WORK?	477.5	DEŞCRIBE HOW IN	IJURY OCCURED	
DESCRIPTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se atsted. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end	s after dea	3 Suicide 8 Could not b	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, s city)	treet, factory, office	28f. L	OCATION (Street a. lity or Town, State)	nd Number or Run	al Route Number,
29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE 29d. DATE SIGNATURE	If ite	(Check only							e(s) end manner es atated.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON, 6121 MONTROSE ROAD ROCKVILLE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	PORT BE	29h. SIGNATURE AND PITE OF CENTER	IER X	70	MD 29c. LIC	ENSE NUMBER	-	29d. DATE SIGN	ED (Mgnth, Day, Year)
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	2 = 2	30. NAME AND ADDRESS OF PERSON V				200	2		1173
		7 - 77			ONIROSE	RUHD	RO	CKVIL	LE
APR 21 1995 Julia Davidson Randall									



8. BIRTHPLACE (State or Foreign

West Virginia

10d. INSIDE CITY

1 - YES 2 NO

White

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 NO

OF DEATN?

29d. DATE STANDE (Month.

Interval Batween

Onset and Death

9c. COUNTY OF DEATN

Harford

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. RACE — American Indian, Black, White, etc.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN essie 4001 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS June 7, 1 M 2 X F 220-24-8839 72 YRS. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Harford Memorial Hospital Havre de Grace RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Cecil North East 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 201 Mechanics Valley Road the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit I Mental Hygiene prior to burial, cremation, or removal. 21901 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married 1 TES 2X NO BY Specify: 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Five Years Homemaker -----17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Garfield Montgomery notified at Rosetta Phillips BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carolyn M. McKinney 201 Mechanics Valley Rd., North East, Maryland 21901 Pe 20a METHOD OF DISPOSITION 1 Description 2 Commetted 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION - City or Town, State Must 3 🗆 R Culpeper National Cemetery 4/25/95 Culpeper, Virginia 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home nomas ATTELLOW Perryville, Maryland event, the medical 23. PART I. Enter the diseases, or complications that caused the dasth. Do not enter the mode of dying, such as cardiac or respiratory street, ahock, or heert fellure. List only one cause on each lin IMMEDIATE CAUSE (Final disesse or condition resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 the death certificate be executed traumatic CERTIFICATION Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL been signed by the pt. of Health and I any 1 TYES 2 X NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. OR ATTENDING PHYSICIAN: The law 8 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER?

1 YES 2 NO HOSPITAL: OTHER: tlant 2 - ER/Outpatient DOA 4 Nursing Nome 8 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE NOW INJURY OCCURED this c marked, 1 Natural 8 Pending Investigation 1 YES 2 NO BY After t 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 8 Could not be DIRECTOR: /

> PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) O

> > 12, REDISTRAR'S SIGNATURE

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

levon

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the Ilms, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

4 Homicide

(Check only one)

29b. SIGNATURE AND TITLE OF CERTIFIER

APR 24 1995

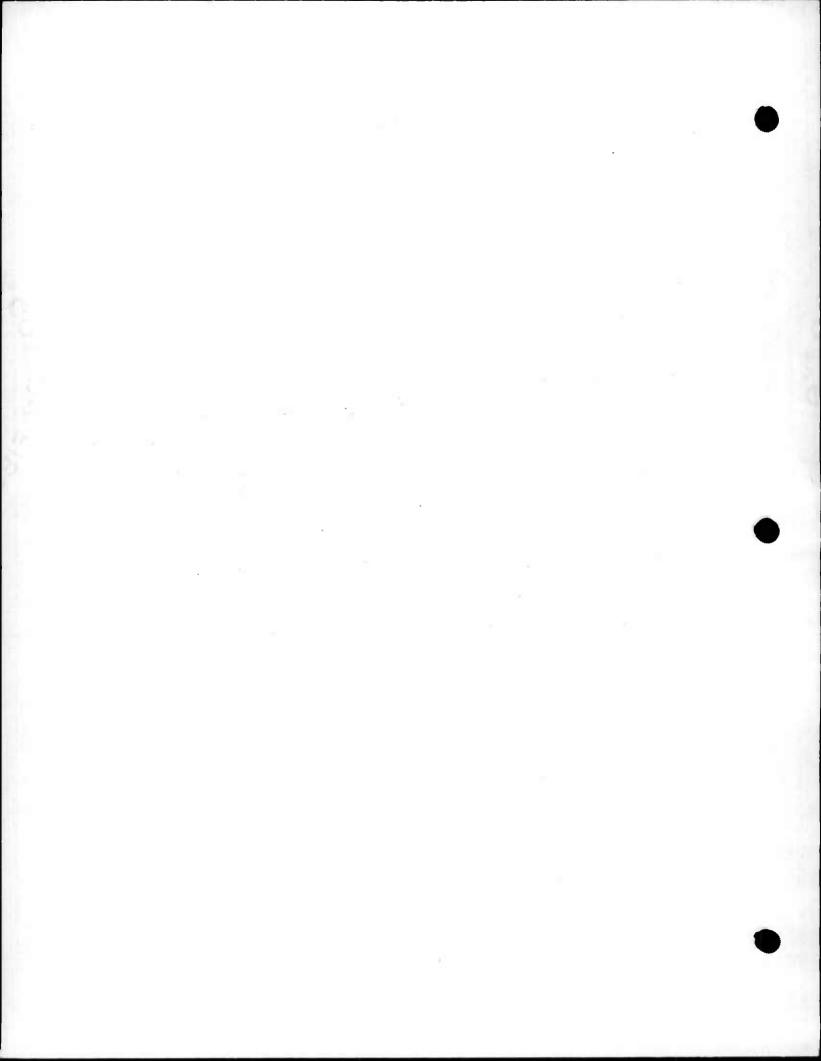
29a. CERTIFIER

28 Hem

> BE 2

TO THE HOSPITAL OF TO THE FUNERAL DID BE filed within 72 ho

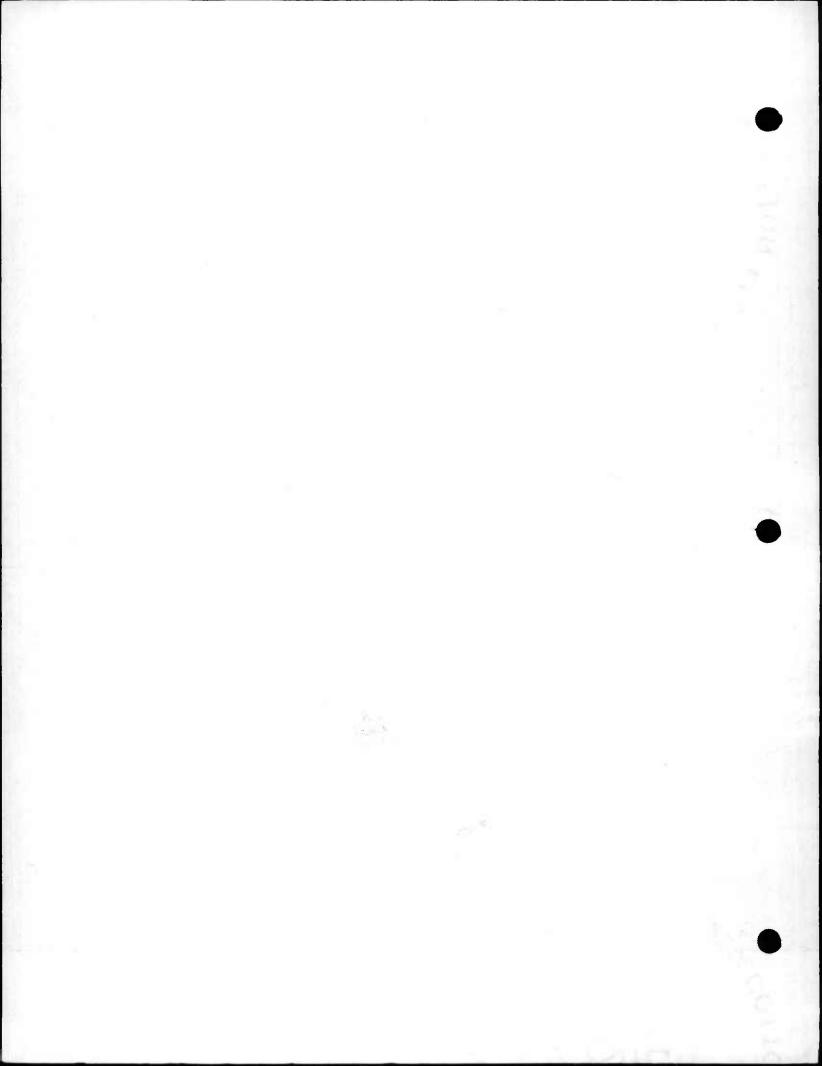
DHMH-16 Rev 1/89



NAME	DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within-or hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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should

	1 - STATE OF MARYLAN		T OF HEALTH AND I	MENTAL HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Lest) gilbert ransom	edwards		2. DATE OF DEATH DA	6 1995	3. TIME OF DEATH			
		yrs. last birthday) IF UNDE YRS. MONTHS	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	Country	PLACE (State or Foreign) nsylvania				
œ	9e. FACILITY NAME (If not institution, give street and number)	y, TOWN OR LOCATION OF DE	DEATH 9c. COUNTY OF DEATH						
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				():	26.1			
DIRE	MD Cecil	Chesa	on Location Deake City		1	10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
	10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF W				
FUNERAL	24 Maryland Ave Hollywood Bea		21915		USA				
ВУ	1 Never Merried 2 Merried FORCES? 1 YES 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATE	2 XNO	WAS DECENDENT OF HISPAN II yes, specify Cuban, Maxica 1 YES 2 NO Specify	n, Puarto Rican, atc.)	or No- 14. RACE Block, Specifi				
TED	(Specify only highest grade completed)	6a. DECEDENT'S USUAL C (Give kind of work done life. Do NOT use retired.)	during most of working	16b. KIND OF BUS					
COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5 +)	Salesman		Automo	bile				
CON	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	ME (First, Middle, Malden	Sumame)	-			
BE	Heath A. Edwards	105 MAILING ADDRESS	Nannie S (Street and Number or Rural I		0 0 0	01015			
2	Connie L. Edwards		and Ave Holly			21915 ake City MD			
	20e. METHOD OF DISPOSITION TYPE Burial 2 Cremetion 3 Removal from State Cemete	LACE AND DATE OF DISPO	SITION (Name of	DATE 20c LOC	CATION — City or Tox	vn, Stata			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	ord Ceme	tery Apr 19	1995	Oxford P	'A			
	interfect f	R	. T. Foard F	uneral Home		01015			
	23. PART I. Enter the diseases, or complications that caused to	he deeth. Do not ante	18 George St			Approximete			
	shock, or heart fellure. List only one ceuse on each immediate CAUSE (Final disease or condition resulting in death)		Onset and Death						
	DUE TO (OR AS A C	ONSEQUENCE OF):			·	30 min			
ATION	Sequentially list conditions, if any, leading to immediate DE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting In dasth) LAST OUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in	Part I. 24a. WAS AN	AUTOPSY 24b.	WERE AUTOPSY FINDINGS			
MEDICAL		A constant		t YES 2	D.NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Z Z	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEA	TH YES NO			1 🗆 YES 2 🗀 NO			
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	OTHE	28. PLACE OF DEATH (Chi	eck only one)					
PHYSICIAN:	1 ☐ YES 2 NO 1 ☐ Inpetient 2 X ER/Outpeti 27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIME OF	zing Home 5 Residence	8 Other (Specify) 28d, DESCRIBE HOW IN	JURY OCCURED				
ВУ Р	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY	WORK? 1 YES 2 NO		30001				
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — building, etc. (Specify)	At home, lerm, streel, fed	tory, office	28f. LOCATION (Street a: City or Town, State)	nd Number or Rural Ro	oute Number,			
COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled EXAMINER: On the basis of examination a					and manner es stated.			
H	296. SIGNATURE AND TITLE OF CERTIFIER Paula aryala mod		29c. LICENSE NUN		29d. DATE SIGNED	Month, Day, Year) 16, 1995			
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	H (ITEM 27) (Type, Print)	ton, md	21921					
	31. DATE FILED (Month, Day, Year) 1995 APR 1 8 1995 July division	Kardall							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

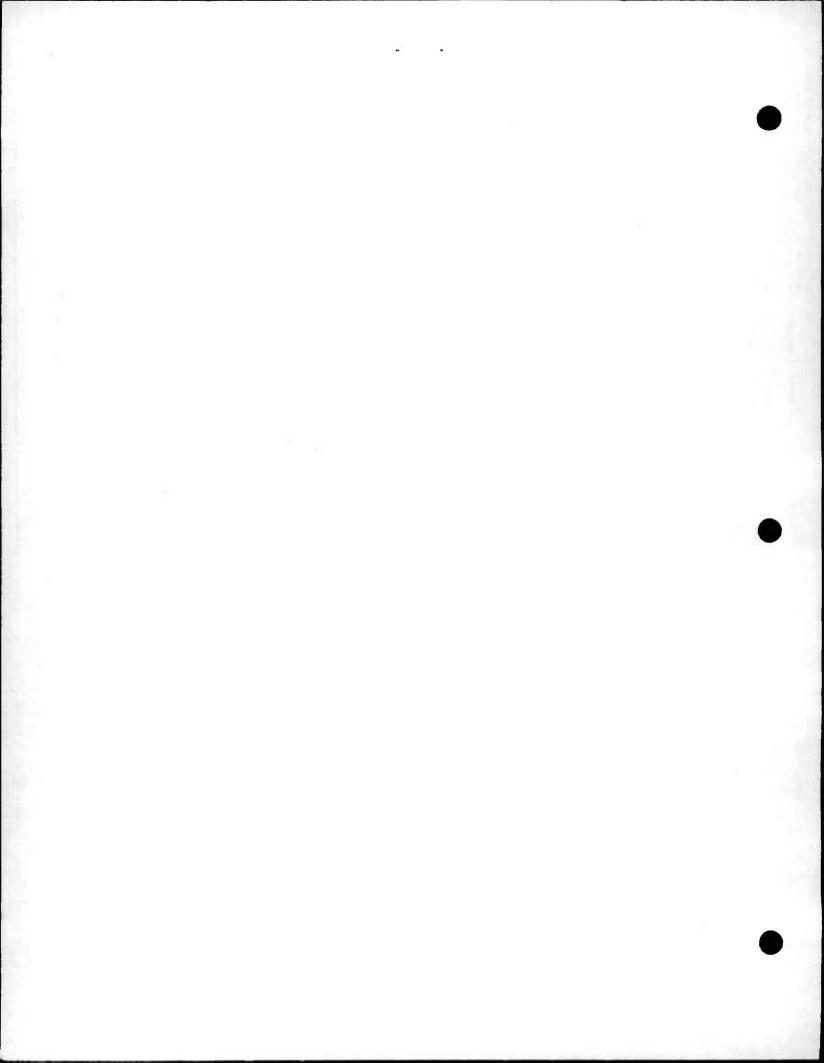
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Sacred Heart Hos										
215-34-4849 9e. FACILITY NAME (If not institution, give:				FRIENI	FRIEND			3. TIME OF DEATH 08:23 A M		
	215-34-4849 1□ м 2次 F			YRS. MONTHS DAYS HOURS MIN.			7. DATE OF BIRTH OCT 11, 1910 8. BIRTHPLACE (State Country) Maryland			
RESIDENCE OF DECEDENT	9e. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital			6. CITY, TOW Cumbe	n or location of di rland	ATH	Allega			
	Maryland Garrett				cation ille			10d. INSIDE CITY LIMITS? 1 □ YES 2 1 NO		
104. STREET AND NUMBER					10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
Toe. STREET AND NUMBER 2609 Blooming RO 11. MARITAL STATUS 1 Name Marital 2 Married	2609 Blooming Rose Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A			13 WAS	21531	IIC ORIGIN? (Specify Ye	USA			
3 Wildowed 4 Divorced	FORCES? 1 1 1 IF YES, GIVE WAR		0	If yes	specify Cuban, Mexica (ES 2 NO Specifi	n, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify: White		
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 8 th 17. FATHER'S NAME (First, Middle, Last)	completed)	(Gh	CEDENT'S US we kind of wor Do NOT use r	k done durina	ATION most of working	16b, KIND OF BU	SINESS/INDUST	RY		
8 th	College (1-4 or 5+)		Homemaker			Own	Home			
				18. MOTHER'S NAME (First, Middle, Maiden Si Anna DeWitt						
19a. INFORMANT'S NAME (Type/Print)					et and Number or Rural i	Route Number, City or Tov				
JoAnn M. Smith				_		., Friends	ville,	MD 21531		
20e. METHOO OF DISPOSITION 1 区 Burlel 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from Stata	20b. PLACE A cemetery, crem	natory or other	r place)	•	OATE 20c. LC	i endsvi			
21. SIGNATURE OF FUNERAL SERVICE LI	21. SIGNATURE OF FUNEHAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A.					
D. Lypa	155 Main St., Grantsville, MD 21536									
immediate Cause (Final disease or condition	disease or condition									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING		JEUN AS A CONSEO UBARA			1 EMORAH	AGE	-+	10 toys		
CAUSE (Disease or Injury	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST C. SUBARACHNOID HEMORRHAGE. 5 WEEK d.									
CAUSE (Disease or Injury that initiated events resulting in death) LAST	d									
that initiated events resulting in death) LAST	d	th but not re	aulting in t	tha underly	ing cause given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS		
CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition	d	th but not re	aulting in t	tha underly	ing cause given in	Part i. 24a. WAS AN PERFOI	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PART ii. Other aignificant condition						PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PART II. Other algnificant condition	RIBUTE TO CAUSI	e of deat		□ NO	UNCERTAIN	PERFO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PART ii. Other aignificant condition		E OF DEAT	H YES	NO	UNCERTAIN	PERFOI	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANNEDOF DEATH	RIBUTE TO CAUSI	28. PLACE	H YES	NO Check only or THER: Nursing H	UNCERTAIN	PERFOI	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO		
PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSI HOSFITAL: 1 [Vinpatient 2 ER/	28. PLACE Outpetlant 3 JRY JURY — At hon	H YES OF DEATH (DOA 4 28b. TIME O	NO Check only or THER: Nursing H F 28c. M	UNCERTAIN ome 5 Residence INJURY AT WORK? YES 2 NO	PERFOI 1 YES :	NJURY OCCURE	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO		
PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF OEATH 1 Netural 5 Pending Investigation	HOSPITAL: 1 [Vinpatient 2 = EN/ 28a. DATE OF INJU (Month, Day. 16 28e. PLACE OF INJ building, etc. (CIAN: To the beat of my k	28. PLACE 28. PLACE (Outpatient 3 PRY Par) (Specify)	OF DEATH (28b. TIME 0 INJURY 20c, ferm, streeth occurred a	INO Check only or THER: Nursing H Set, factory, or	UNCERTAIN TO OTHE 5 Residence INJURY AT WORK? YES 2 NO Iffice ets and place, and due	8 Other (Specify) 28d. DESCRIBE HOW I City or Town, Stete) to the cause(s) and mai	NJURY OCCURE	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO		
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PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSI HOSPITAL: 1 (Windth, Day, Ye 28a. PLACE OF INJU 28b. PLACE OF INJU 28c. PLACE OF INJU CIAN: To the best of my k R: On the basis of sxamir	28. PLACE 28. PLACE Coutpetlent 3 (Specify) Crowledge, dea	TH YES OF DEATH (DOA 4 28b. TIMEC O INJURY THE, farm, streeth occurred a twestigation, i	NO (Check only of the R: Nursing H Y M 1 [et, factory, of the time, d in my opinion	UNCERTAIN DO OME 5 GRANDENCE NAJURY AT WORK? YES 2 NO Hose At and place, and due do death occurred at the 29c. LICENSE NUM 2 3 3	8 Other (Specify) 28d. DESCRIBE HOW I 28t. LOCATION (Street City or Town, State) to the cause(a) and mai	NJURY OCCURE and Number or Re nner as stated. d dus to the cau 29d. DATE SIG	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO D ural Route Number, ree(a) and manner as stated. NED (Month, Day, Year)		



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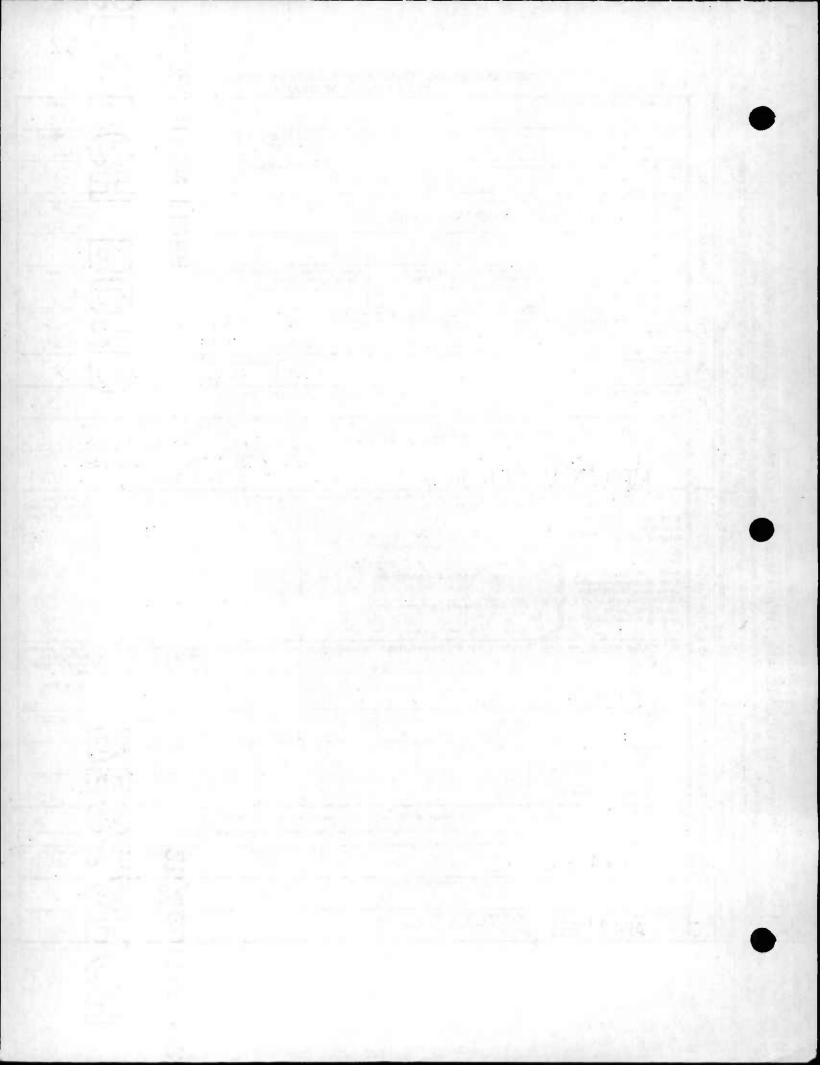
1. DECEDENT'S NAME (First, Middle, Last)

DIVISION OF VITAL RECORDS,

2. DATE OF DEATH 3. TIME OF DEATH 18", 1995" EAR 12:15 A.M Walter William Frauman, IV April 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) October 22, 1961 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 266-63-0297 33 1 X M 2 | F DAYS HOURS VRS South Carolina Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5-H Eastway Road Greenbelt DIRECTOR Prince George's RESIDENCE OF DECEDENT Maryland Prince George's 10c. CITY, TOWN OR LOCATION Greenbelt 10d. INSIDE CITY 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5-H Eastway Road 20770 use as the burial-transit United States the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Ricen, atc.)
1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 021215-0020 1 Never Married 2 X Merried BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade come United States Government è Elementery/Secondery (0-12) College (1-4 or 5+) 12 detached Social Security Specialist Social Security Administration 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) Walter William . Frauman, III To Sally Annette Crosby retained by page 5 should be BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str and Number or Rural Route Number, City or Town, State, Zip Code 9 Deanna Lynn Peel (wife) same as #10 å 9 20e. METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 Ren may 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must director. 4 Donetion Metropolitan Crematory Page 6 5 Other (Specify) April 19,1995 Alexandria, Virginia examiner Donald V. Borgwardt Funeral Home, P.A. funeral 4400 Powder Mill Rd. Beltsville, Md. 20705 the f medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one house on each line. filled in by Approximata Interval Batwean 5 IMMEDIATE CAUSE (Final Onset and Death cremation. the disease or condition resulting in death) Cardiopulmonary Arrest Minutes completely event, DUE TO (OR AS A CONSEQUENCE OF): executed burial. Non Hodgkin's Lymphoma 2 years traumatic CERTIFICATION and Sequentially list conditions. 20 DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING physician 2 Drior death certificate CAUSE (Disease or Injury other the attending phy d Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by ti AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TYES 2 NO law requires 1 TYES TO NO 50 has be Dept. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL OR ATTENDING PHYSICIAN: The 26. PLACE OF DEATH (Check only one) Item certificate t EXAMINER? OTHER:
4 □ Nursing Home 5 N Residence 8 □ Other (Specify) HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 0 the 27. MANNER OF DEATH 28e, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED this c marked, 5 Pending Investigation XX Natural 1 YES 2XXNO BY After death 2 Accident DIRECTOR: Aft hours after dea item 28 is n 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29e. CERTIFIER
(Check only)

1 XXERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner as stated. 2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Balband 18948 ▶ April 19, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Imad Tabbara, M.D. 2150 Pennsylvania Avenue, N.W. Washington, D.C. 20037 31. DATE FILED (Month, Day, Year) A REGISTRATE SIGNATURE APR 20 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

	_	REGISTRAR			CERTIF	CATE	OF DEATH		REG. NO	D		
	- 3	1. DECEDENT'S NAME (First, Middle, L	.est)					2.	DATE OF DEATH			3. TIME OF DEATH
	- 1	PEGGY	FITZPATRICK					APR. 20. 1995 12:30 AM				
	- 3	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				DATE OF BIRTH	يل ول	\sim	IPLACE (State or Foreign	
	- 3	215-54-5792	1 □ M 2 1 F	66	YRS.			ARM.	(Month, Day, Year) AN . 22,	1000	Count	(Y)
8	. 4	9e. FACILITY NAME (If not institution,								-		. CAROLINA
3 should	œ					96. CITY, TO	WN OR LOCATION			9c. COU	INTY OF D	EATH
N	CTOR	10308 DETRIC					KENSING!	TON			MONI	GOMERY
-i	ш	10e. STATE 10b. CO			10c CITY	, TOWN OR	OCATION					
S	DIR				100.011			_				10d. INSIDE CITY LIMITS?
			ONTGOMERY			KEN	SINGTON	1				1X YES 2 NO
ē.	MA	10e. STREET AND NUMBER					101. ZIP CODE			10g. CIT	IZEN OF V	WHAT COUNTRY?
DUNAH-UANSI	FUNERAL	10308 DE	TRICK AV	E.	_		208	395			U.S	.A.
-	5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	T EVER IN U.S.	ARMED	13. WA	DECENDENT OF H	ISPANIC C	RIGIN? (Specify Ye	a or No-	14. RACI	E — American Indian,
		1 Never Married 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE W		∠ NO	1 [es, specify Cuben, N YES 2 X NO	Aexicen, Pu Specify:	uerto Ricen, etc.)		Spec	k, White, etc.
	BY	3 12 Wildowed 4 Divorced					22					WHITE
900	G	15. DECEDENT'S (Specify only highest		18e.	DECEDENT'S		PATION ng most of working		16b. KIND OF BI	JSINESS/INI	DUSTRY	
	ᇤ	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	life. Do NOT us	e retired.)	ig most or working					
	릴	12			HOI	SEWI	F E			AT I	TOME	
notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		1100	, <u>, , , , , , , , , , , , , , , , , , </u>		'S NAME (First, Middle, Maide		10111	
at 6	EC	MONROE	H. ED	WARDS	2			UBY	MAE	,	nmen	FIELD
8	8	19e. INFORMANT'S NAME (Type/Print)	*** 110	T		4DDD=00.00						C TEPD
notified	2		TO DA MD T OU				treet end Number or i			wn, State, Zij	p Code)	
be		SUSAN C. FI		7	SAM			1 #T	0			
must	- 1	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3	Removal from State		CEAND DATEO				111	DCATION —	City or To	own, State
Ē		4 Donetion 5 Other (Specify)		CHA	MBERS	CRE	MATORY	4,	/21 I	RIVE	RDAL	E, MD.
examiner		21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	1		22. NA	ME AND ADDRESS	OF FACILIT	Υ	T 17-1		DING NO
xam		1/1////	ambun	all N	100091	Y. 7	T-7 CITTA	MDDI	27	TIAET	X SP	RING, MD.
ai ai	-	00 DATE FALSE	winning				W. CHA					20910
or remove		23. PART I. Enter the diseases, ahock, or heart faile	ure. List only one caus	caused the se on each I	death. Do n lina.	Dt anter th	moda of dying,	, auch as	cardiac or rasp	oiratory ar	rast,	Approximata interval Between
		IMMEDIATE CAUSE (Final				_	. 0					Oneat and Death
natio		disease or condition resulting in death)	ER4	AST	· (AN	CER					3
c event, the medical examiner must be		rooming in again,	DUE TO (OR AS A CON	SEQUENCE OF			-				Byzons
Health and Mental Hygiene prior to bural, ws any injury, or other traumatic en	z											
prior to buris	ERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (DUE TO (OR AS A CONSEQUENCE OF):								
tra	¥ I	cause. Enter UNDERLYING										
Hygiene or other	Ē	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A CON	SEQUENCE OF):						
T ya	E	resulting in death) LAST										
Trail	8		d									
th and Menta any injury,	U1	PART II. Other aignificant cond	Itiona contributing to	death but no	ot resulting l	n tha unda	lying cause give	n In Part	i. 24a, WAS AI	N AUTOPSY	24b	WERE AUTOPSY FINDINGS
a an	EDICAL								PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ws a									1 TYES	2 MINO		OF DEATH?
sho	Σ	DID TODA CCO HAT GO							_			1 YES 2 NO
be filed within 72 hours after death with the State Oept. of IMPORTANT: If Item 28 is marked, or Item 23 sho	PHYSICIAN:	DID TOBACCO USE CO						TAIN [
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or is	Z I	1 TES 2 NO	1 🗆 Inpstient 2 🗆	ER/Outpatient	3 🗆 DOA	OTHER: 4 Numing	Home 5 Reelde	ence 8 🗆	Other (Specify)			
₽ 9	F	27. MANNER OF DEATH	28e. DATE OF ((Month, Da		28b. TIME		: INJURY AT WORK?	280	. DESCRIBE HOW	INJURY OC	CURED	
ark v	Β¥	1 Natural 5 Pending 2 Accident Investigat		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2 N	。				
dea s m		3 Suicide 8 Could not	28e. PLACE OF	INJURY — At	home, ferm, s	treel, factory,	office	281	LOCATION (Street	and Number	or Rural F	Route Number,
28 Z8	ETED	4 Homicide delermine		Mc. (Specify)					City or Town, State)		
Surs ea	Щ	29e. CERTIFIER	dter in vice									
12 H	Ē	(Check only	HYSICIAN: To the best of r									
E N	COMPL	2 MEDICAL EXA	MINER: On the beele of ex	amination end/	or investigation	n, In my opini	on, death occured s	st Ihe time,	, date end place, e	nd due lo th	le Ceuse(e) end menner ee stated.
BTA	ш	296. SIGNATURE AND THE OF CHIT	TERR I				29c. LICENSE	E NUMBER		29d. DAT	E SIGNED	(Month, Day, Year)
M P a	∞	Daniel 16	all		M	1)	An	176	26	> 4	f-2e	2-95
0 ==	임	30. NAME AND ADDRESS OF PERSON DANIEL ROSE	WHO COMPLETED CAUSE	E OF DEATH (TEM 27) (Type.	PHNI)	100	. , .		<u> </u>		70
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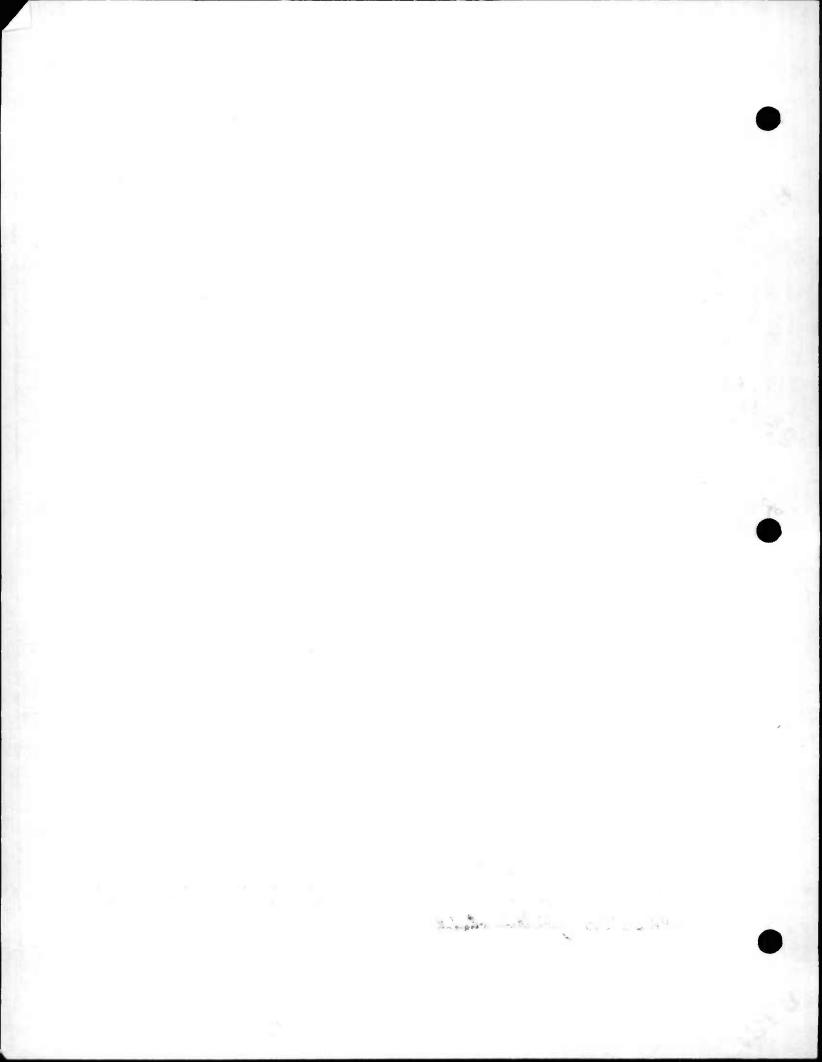
9 17

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTA	MENT OF H	EALTH AND I		YGIENE EG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF D	EATN		3. TIME OF DEATN
	BABY BOY		F	ASCELLI MARCH 2			27. 19	995	11:55P M
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B (Month, Day	eRTH .	6. BIRT	HPLACE (State or Foreign
		1 □ M 2 🔀 F	YRS.	NTHE DAYS	HOURS MIN.	March	21,199	5 Ma	ryland
~	9a. FACILITY NAME (If not institution, give stre		98	. CITY, TOWN C	R LOCATION OF DE	EATN		OUNTY OF I	
0	THE JOHNS HOPK	INS HOSPITAL		BALTI	MORE CIT	ΓY	В	altim	ore
EC	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION				10d, INSIDE CITY
듬	Maryland Washi	ington	erstown	1				LIMITS?	
AL	10e. STREET AND NUMBER			101				CITIZEN OF	WHAT COUNTRY?
FUNERAL DIRECTOR	11310 Englewood Ro	oad			21740		U	ISA	
5		12. WAS OECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF NISPAN	NC ORIGIN? (Sp	ecify Yas or No-	- 14. RAC	E — American Indian,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES	elfy Cuban, Maxica 2 NO Specify		, etc.)	Spec	ck, White, etc.
	15. OECEDENT'S EOUCA	TION	16a. OECEDENT'S US	IAL OCCUPATIO				1	White
ETE	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo-	st of working	16b. KINI	O OF BUSINESS/	INDUSTRY	
PL	none	College (1-4 of 5+)	none				none		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle	, Maiden Sumame	p)	
BE C	Rikki Alan Parks	, Sr.			Traci	Michel	e Wol	ford	
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural F	Route Number, Ci	ity or Town, State,	Zip Code)	1.047/0
-	Rikki A. Parks, S	Sr.	11310 E	ng Lewoo	nd Road	Hagers	town, M	laryla	and 21740
	20s. METHOD OF OISPOSITION 1 X Burlal 2 Cremation 3 Remove		PLACE AND DATE OF CO			OATE 2 /20	20c. LOCATION	— City or To	own, State
	4 Donation 6 Other (Specify)		est Haven		•		nagers	LOWII,	Maryland
	(b) 00 V	Millian		Geral	N. Minr	nich	305 N.	Poton	nac Street
	server of,	9 1 WWW	LCN.	Funera	1 Home				Maryland /
	23. PART I. Enter the dieeeses, or con ahock, or heert fellure. Lie	mplicetions that caused at only one cause on ea	the deeth. Do not ch line.	enter the mod	de of dying, eucl	h es cardiec	or reepiratory	srrest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel							Onset and Death	
	disease or condition reculting in death)	Williac							10 minutes
_		DUE TO (OR AS A	1	< n' cu	Li nos				100
<u>S</u>	Sequentially liet conditions, if sny, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF:	spira	20113				20 minure
PA	cause. Enter UNDERLYING	Bruin	Stem]	Ische	mia				3 days
Ē	CAUSE (Disease or Injury that initiated events		CONSEQUENCE OF):						0 0.043
CERTIFICATION	resulting in death) LAST	Neona-	tal Asi	shy xi	2				le days
SAL	PART II. Other significant conditions	contributing to deeth bu	t not resulting in t	he underlying	ceuse given in	Part I. 24a.	WAS AN AUTOPS	Y 24b	. WERE AUTOPSY FINDINGS
<u>S</u>							PERFORMEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						_ ' -	YES 2 NO		OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	<u></u>			1 123 2 100
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF OEATN (
YS!		HOSPITAL:		THER: □ Nursing Nome	5 - Residence	6 Other (Spe	city)		
F	27. MANNER OF DEATN	26a. OATE OF INJURY (Month, Day, Year)	26b. TIME OF		JRY AT	26d. DEŞCRIB	E HOW INJURY	OCCURED	
B	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO				
	3 Suictde 6 Could not be 4 Nomicide determined	26s. PLACE OF INJURY - building, etc. (Specif	— At home, term, stree y)	t, factory, offica		26t. LOCATION City or Tow	(Street and Num. rn, State)	ber or Rural I	Route Number,
<u> </u>									
M M	(Check only CERTIFYING PHYSICIA	AN: To the best of my knowle							
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and n									a) and manner as stated.
BE	29b, SIGNATURE AND TITLE OF CERTIFIER	mN			29c. LICENSE NUM	IBER	29d. D	21.0	(Month, Day, Year)
၀	30. WAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OEAT	TH (ITEM 27) (5 C	Mr)	T-70 (01		3/28	CP11
	of abacoula Vi	ennus las	M. WO:		- Ruls	HimN	e, m	V -7	1787
	BATTAGE ENTED (WAGO CAE YOUR)	Wash redistants a light	TURE	1001	· Dall	011101	C 1111	20	1001
	MIHL 2 T 1323 Surva	The same of the same							1
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	FOR STATE REGISTRAR
ı	1. DECEDENT'S NAI
	Mary
ı	4. SOCIAL SECURIT
1	577-48-
١	9a. FACILITY NAME
1	Physici RESIDENCE O
ķ	RESIDENCE O
	MD
ļ	10e. STREET AND N
ı	10481 Wi
I	11. MARITAL STATUS
N	1 Never Married
	3 X Widowed 4
I	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

		1. DECEDENT'S NAME (First	, Middle, Last)		_						2. DATE OF DEATH			3. TIME OF DEATH
		· E	Leanor				F_1	llner		1	pril 20	199	5 YEAR	6:30 A M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In s	rrs. last birthd		IF UNDER 1 YEAR IF UNDER 24 HRS.							
		577-48-190		1 M 2 XF	83	YR:	MO	NTHE DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)		Countr	**
pino					0.5			OUT V TOWN						nesboro, PA
3 should)H										nty of b			
the bunal-transit permit. Pages 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT												
sage,	H									10d. INSIDE CITY LIMITS?				
if.		MD	Char	les		W	hite	<u>e Plai</u>	ns					1 TYES 2 NO
t peri	FUNERAL	10e. STREET AND NUMBER						-10	of. ZIP CODE					VHAT COUNTRY?
transi	N	10481 Wille	etts Cr		_					069			SA	
-igi-		11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES :	2 XNO					IC ORIGIN? (Specify Yes	or No-	14. RACE Black	— American Indian, c, White, etc.
age of	ВҰ	3 XWidowed 4 Dive		IF YES, GIVE V	WAR OR DATE	S		1 🗌 YE	S 2 1 NO	Specify	:		Speci	White
use as	ED		EDENT'S EDUC		16	e. DECEDEN	T'S USU	JAL OCCUPAT	ION		16b. KIND OF BUS	SINESS/INC		
So re	COMPLETED	Elementary/Secondary (0	y highest grade 0-12)	College (1-4 or 5	+)	(Give kind life. Do NO	of work Tuse rei	done during m tired.)	ost of working	g				
ped 1	린			4		Nurs	e				Hospita	al		
once.	Ö	17. FATHER'S NAME (First, M							18. MOTH	IER'S NAI	ME (First, Middle, Maiden			
3	BE	Daniel Sing	ger Gei	ser					Ele	eanor	Brubaker			
notified	2	194. INFORMANT'S NAME (7				19b. MAIL	ING ADO	DRESS (Street	end Number	or Rural A	loute Number, City or Town	n, State, Zip	Code)	
be no	۴	Jon S. Fell	ner			1048	1 W:	illett	s Cro	ssir	ng RD, Whi	te Pl	ains	, MD 20695
rureral director, page 5 should be detached for caminer must be notified at once.		20a. METHOD OF DISPOSIT 1 💢 Burial 2 □ Crematic		oval from State	20b. PL	ACE AND DA	TE OF D	ISPOSITION (A	lame of			CATION —		
		4 Donation 5 Other		40	, Gr	een H	ill	Ceme t	ery		4/22 Wayı	nesbo	oro E	PA 17268
e runeral di li. examiner		21. SIGNATURE OF FUNERA	mes a	100	berne						Grove F			
			A. Bow	ersox	every			50 S.	Broa	ad ST	r, Waynesb	oro,	PA 1	.7268
or removal.		23. PART I. Enter the d	iseesea, or c	omplications the	t ceused th	ne deeth. D	o not	enter tha m	ode of dyl	ng, auch	ea cardiac or reapi	ratory an	reat,	Approximete
. or .		immediate cause (Fir		Liat only one cau	ise on each	Ilne.	1	A						Interval Between Onset and Death
nation.		disease or condition resulting in death)	→ .	Re	spen)	M	lu						
enoing prysician and complete I Hygiene prior to burial, crema or other traumatic event,				DUE TO	(OR AS A C	NSEQUENCI	E OF):	Fi						
burial stic	Z	Sequentially list condit	lone C	1 Mg	fun	Puls	ns	L	lyn	p				
signed by the attending physician and completely me Health and Mental Hygiene prior to burial, cremation, ws any injury, or other traumatic event, the	Ĕ	If any, leading to imme-	diata	DUE (76	(OR AS A CO	NSEQUENC	E OF	,						
er tr	CERTIFICATION	CAUSE (Disease or Inju		DUE TO	(OD 40 4 00	MARCHENO								
bygien the	Ē	that initiated events resulting in death) LAS	т	DUE 10	(OR AS A CO	INSEQUENCI	E OF):							
y, o	E													
f Health and Mental		PART II. Other significa	nt condition	contributing to	death but	not resultin	ng In th	na undarlylr	g cause g	Ivan in I			24b.	WERE AUTOPSY FINDINGS
any an	MEDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Heal OWS	Ä											X		OF DEATH? 1 YES 2 NO
3 sho	_	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF I	DEATH	YES	□ NO [UNC	ERTAIN	i izk			
e State Dept. or	ĕ I	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		26.	PLACE OF D	_	check only one,						
the Sta	S	1 TES 2 X NO		HOSPITAL:	ER/Outpatie	ent 3 🗆 DO/		HER: Nursing Hor	ne 5 🗆 Res	sidence (8 Other (Specify)			
ed, the	PHYSICIAN:	27. MANNER OF DEATH		26e. DATE OF (Month, D	INJURY ay, Year)		TIME OF		JURY AT DRK?		28d. DESCRIBE HOW I	JURY OC	CURED	-
r death with	BY		Pending Investigation						YES 2	NO				
after death with 28 Is marked,			Could not be	26e. PLACE O building.	F INJURY — atc. (Specify)	At home, far	m, atreel	t, tactory, offic	ce		26t. LOCATION (Street a City or Town, State)	nd Number	or Rural R	oute Number,
m 28	COMPLETED	4 Homicide	datermined											
hours a	7	29e. CERTIFIER (Check only 1 X CERT	IFYING PHYSIC	IAN: To the best of	my knowledg	ge, death occ	urred at	the time, dete	e end place,	end due 1	to the cause(s) end men	ner es atat	ed.	
NT: II	8	one) 2 MEDI	CAL EXAMINE	R: On the basis of e	xamination en	id/or investig	ation, in	my opinion,	death occure	ed at the t	time, date and piece, and	d due to th	e ceuse(s)	end menner es stated.
RTA With	ш	29b. SIGNATURE AND TITLE	OF CERTIFIER	1 11	_1 .				29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
be filed within 7	8	min	N	Jews	VI, Y	nr			D-	-210	31	1 4	1/20	195
-	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH	(ITEM 27) (7	ype, Print	Wald	orf N	Medi	cal Park	P.	Ó. Bo	x 249
		Michael Le	eather	wood,M	D						Marylan			
- 1		3'APR"2 "1"199	Sar) Jula	RESISTRA	SHOPATH	AE .								
i		711 11 4 1 100	0			1								



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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per	20	undersary: it ham 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at one

BE

2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH GEORG 8:5 10 D 7. DATE OF BIRTH (Month, Day, Yea 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 F 38-40-4085 Pa 22 - 199a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Chesapeake Manor Nursing Ctr. Arnold Anne Arundel 10b COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Arnold 1 YES 2 X NO Anne Arundel MD 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 101. ZIP COOE 21012 213 Doncaster Rd. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 V YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Ri

1 YES 2 NO Specify: 1 Never Married 2 X Married Specify: BY 3 Widowed 4 Divorced 1943-1976 White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl П Fiementany/Secondary (0-12) College (I-4 or 5 +) COMPL 5+ Marine Corps. Military 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Sumame) Jean Christie Bull Richard Lauman Fox 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 213 Doncaster Rd. Arnold MD 21012 Frances G. 20s. METHOO OF DISPOSITION
1XC Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or Arlington, Va. rlington National Cem 21. SIGNATURE OF FUN TAL BENOCE LICENSEE 22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco & Sons FH Severna Park MD 23. PART . Enter tha diseasea, or complications that caused tha daath. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Interval Batween **Onset and Death** iMMEDIATE CAUSE (Final disease or condition resulting in death) Meta state DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to death but not reaulting in the underlying ceuse given in Pert i. CAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO MEDI DF DEATH? 1 TYES 2 NO ICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) OTHER: 1 YES 2 -NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA PHYSI ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 1 Natural 5 Pending 1 YES 2 NO ΒY 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide ETED. 6 Could not be determined 4 Homicide 29a. CERTIFIER 1 SCRTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and memor as stated. 296. SIGNATURE INO TITLE OF CERTIFIER

P Doctor

bwy

CRAIN

Actem

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

-M-D

29c. LICENSE NUMBER

#106

216

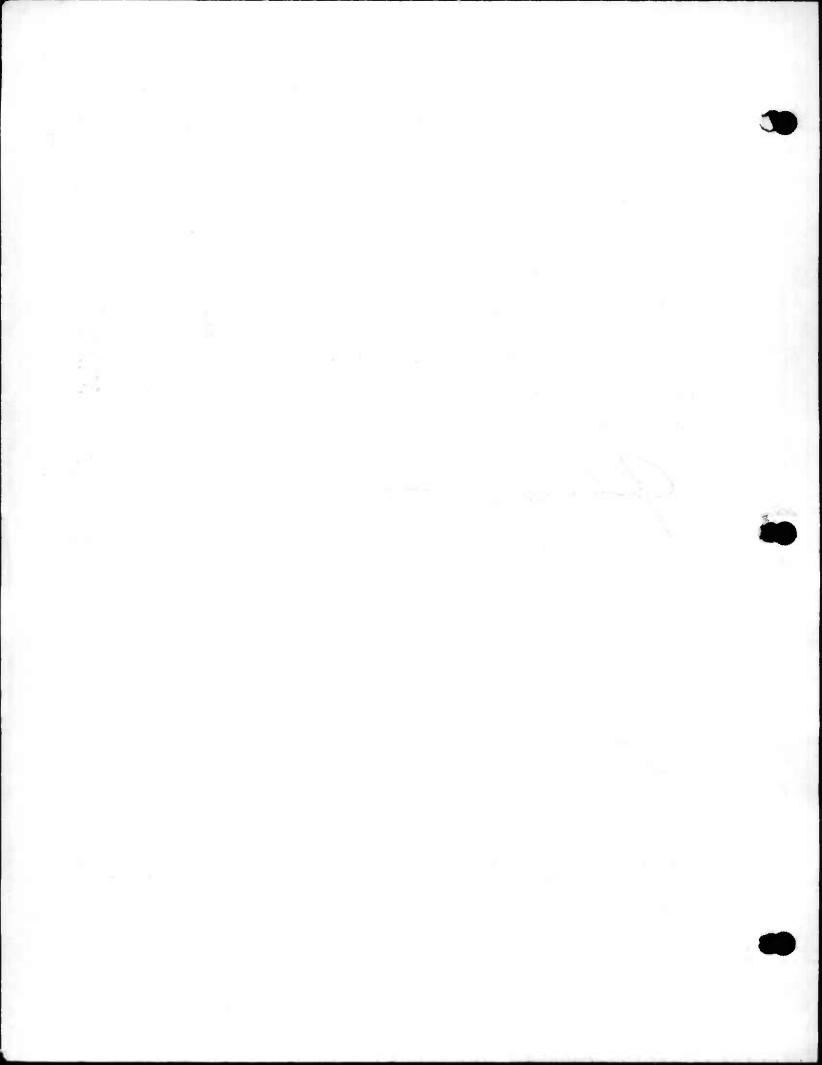
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29d. DATE SIGNED (Month

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CERTIFICATE **

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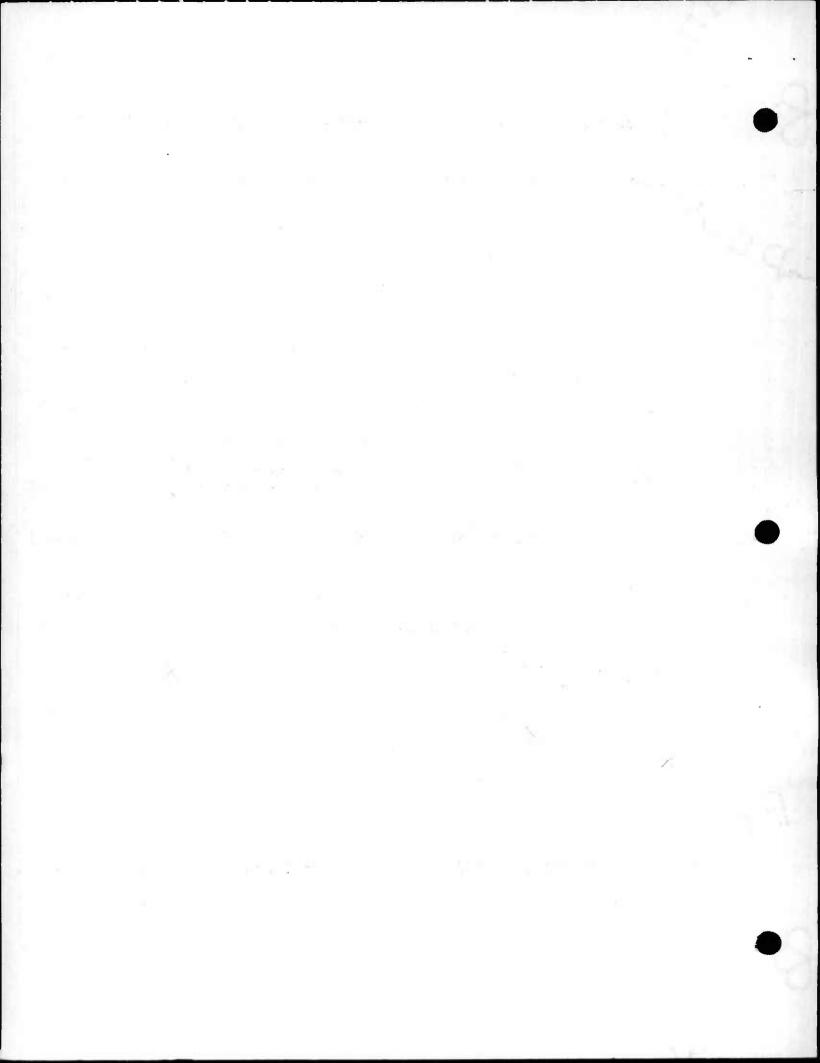
CERTIFICATE **

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THE RESERVE TO SERVE

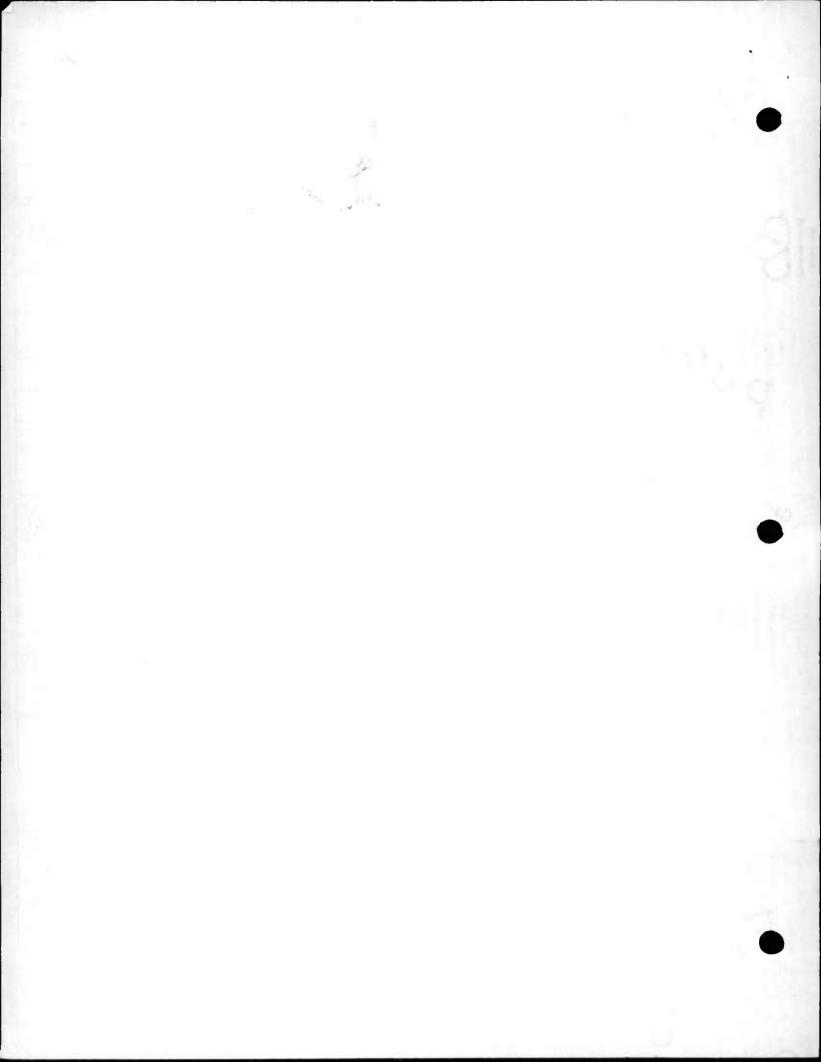
DIVISION OF VITAL RECORDS, P.O. BOX 68/64 A BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	OF MARYLAND	DEPARTM				AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				DEATT	2. DA	TE OF DEATH			TIME OF DEATH	
- 8	ALFHILD L			JSTEL		ΑP	RIL .	ľ6, 1	1995	2:20	$\mathbf{a}_{\mathtt{M}}$
1	4. SOCIAL SECURITY NUMBER 5. SEX 15.7-30-8693 1 M 25	6. AGE (In yrs. la	MO	UNDER 1 YEAR	IF UNDER 24 I	m. (Mo	E OF BIRTH onth, Day, Year)		8. BIRTHPL. Country)	ACE (State or Fore	ign
	9e. FACILITY NAME (If not institution, give street and numb		YRS.	CITY TOWN C	D I COSTTON		13/19			eden	
DIRECTOR	SAINT JOSEPH MEDICAL CENTER TOWSON, MD BALTI										
E C	RESIDENCE OF DECEDENT										
ä	MD. Carroll		W	estmin	ster			LIMITS?	10		
FUNERAL	100. STREET AND NUMBER 4626 Old Hanover Rd				101. ZIP CODE 10g. CITIZEN OF WH						
S	CODOLO	CEGENT EVER IN U.S. AI					IN? (Specify Ye			American Indian	١,
BY		7 1 TYES 2 X GIVE WAR OR DATES	NO		2 NO	fexicen, Puert Specify:	o Ricen, etc.)		Black, W Specify:		
	15. DECEDENT'S EDUCATION	140.00	ECEDENT'S USU		22					white	
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(0	live kind of work	done during mo- tired.)	st of working	'	8b. KIND OF BU	SINESS/INO	USTRY		
립	8		ngeri	e dist	ribu	tor	facto	ry -	ling	gerie	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	'S NAME (First	, Middle, Meiden	Sumame)			
BE (John Emil Carlson				Je∶	nnie	Alexi	na Lo	ofgri	n	
6	19e. INFORMANT'S NAME (Type/Print)						mber, City or Tow			211!	58
	Pam Holmes 20a. METHOD OF DISPOSITION						West			Md.	30
	1 Buriel 2 Cremation 3 Removal from Sta 4 Donation 6 Other (Specify)		and date of demander of the C.			1 1			City or Town,		a .
	21. SIGNATURE OF FUHERAL SERVICE LICENSEE	Carr	OII C.						2115	ead, Mo	٦.
	VISoit A. Mar	2					Hom			1	
	23. PART I. Entar the diseases, or complication	e that council the di	neth Do not							SREKII	
	shock, or haart failure. List only or	a causa on each line	atn. Do not o a.	entar tha mo	da of dying,	auch ss cs	rdiec or reap	iratory arra	nst,	Approximate interval Bat	ween
	IMMEDIATE CAUSE (Finel disease or condition	n aumont	OD WW	003.00	TAT T	MEXIC	MT ON			DAYS	
i		E ANTERI UE TO (OR AS A CONSE		UCARD.	LAL I	MEARC	TION			DAIS	
z		ESTIVE H	EART	FAILU	RE					DAYS	
ST.	I IT BOY, leading to immediate	UE TO (OR AS A CONSE		a 500	nom					DAVC	
걸	CAUSE (Disease of Injury	RICULAR JE TO (OR AS A CONSE		C DEF	ECT					DAYS	
CERTIFICATION	manufilms in death LACT	MYALGIA		ATICA						YEARS	
	PART II. Other significent conditions contributi	ng to death but not	requiting in the	ne underlylas	Cause obse	n in Part 1	24a. WAS AN	ALITYORGY	945 1110	RE AUTOPSY FIND	VID. 0.0
3	AORTIC REGURITATIO		cualting in ti	re direallying	Couse give	n in raiti,	PERFO	MED?	AM	THE AUTOPSY FINE ARLABLE PRIOR TO IMPLETION OF CAU	
Ē	SEIZURE DISORDER						1 TYES 2	NO	OF	DEATH?	
3	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEA	TH YES	П по П	UNCER	TAIN 🗆	1		1 1	YES 2 NO	,
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH (C		0.100.1						
SIC		L: t 2 ER/Outpatient 3		THER: Nursing Home	5 🗆 Reside	nce 6 🗆 Oti	ner (Specify)		_		
PH	(M	TE OF INJURY onth, Day, Year)	28b. TIME OF	28c. INJU	JRY AT	28d. O	ESCRIBE HOW	NJURY OCC	UREO		
2 Accident Investigation M 1 YES 2 NO											
COMPLETED	9 Culatta - 1 288 PLACE OF IN III DY - At home form street feature office										
1	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the b	est of my knowledge, de	eth occurred at	the time, date	and place and	d due to the c	ausa(a) and ma	oner ee etete	ad .		
NO N	one) 2 MEOICAL EXAMINER: On the bee									id manner ee stat	led.
	29b. SIGNATURE AND TITLE OF CERTIFIER	\wedge		T	29c. LICENSE					opth, Day, Year)	
) BE	(evallos	m			D 25	886		D 4	4.16	· ar	
2	30. NAME AND AODRESS OF PERSON WHO COMPLETE							03.55		12	
	DR CEBALLOS 7	520, YORK	ROAD	WOT	SON,	MARY	LAND	2120	4		
	APR 1 7 1995	SHI AND AND AND AND									

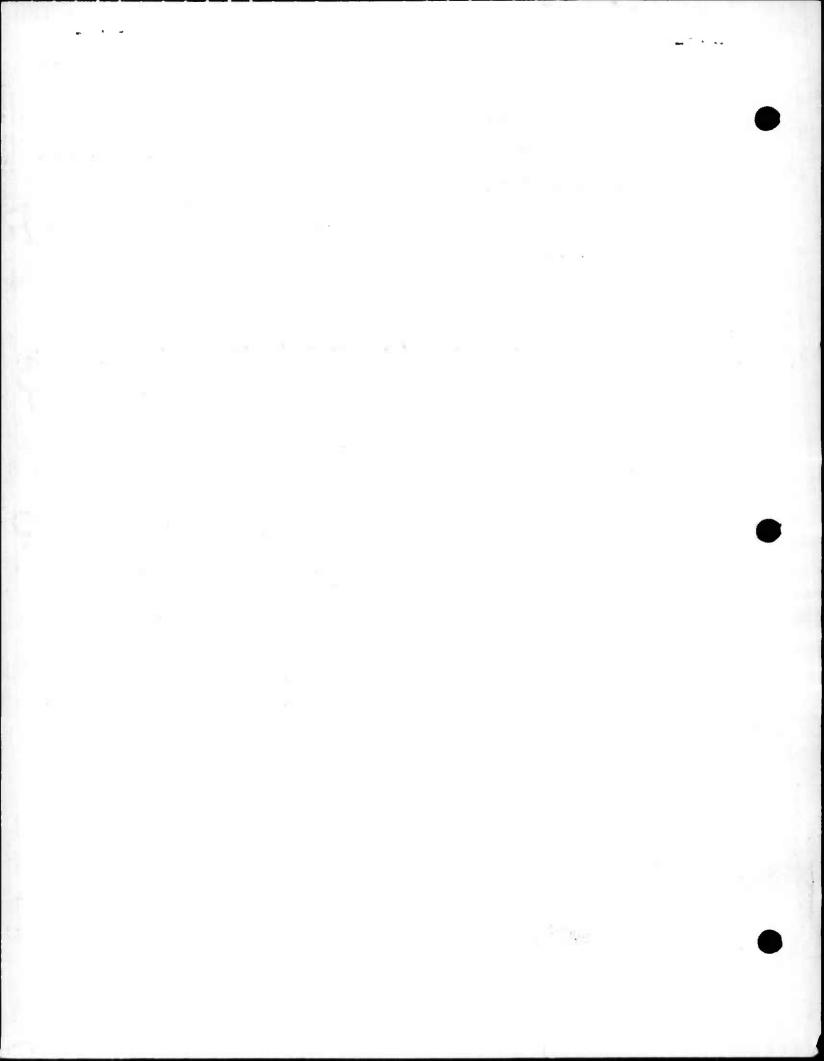


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

		REGISTRAR		CI	ERTIFIC	ATE (OF DEATH		AEG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) Robert Lee		FI	etche	2-1-		2. DATE MONTI	OF DEATH	w / g	YEAR	3. TIME OF DEATH 21 · 55 M
				(In yrs. les	7.	UNDER 1 YE		7. DATE	OF BIRTH	1	8. BIRTH	PLACE (State or Foreign
		231-42-8381	1 🕅 M 2 🗌 F	59	YRS.	NTHS DA	YS HOURS MIN.	4/1	4/193	5	Vir	ginia
		9a. FACILITY NAME (If not institution, give atre				. CITY, TO	WN OR LOCATION OF				NTY OF DE	
	6	Carroll County (General H	ospi	ta1	Wes	stminste	r		Car	rol	1
		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY, T	OWN OR LO	OCATION					10d. INSIDE CITY
	DIRECTOR	Virginia n/a	a		Ches	apea	ake					LIMITS?
	A P	10a. STREET AND NUMBER					101, ZIP CODE			10g. CITI		THAT COUNTRY?
	띨	1218 Lilac Aver	nue				23325			Uni	ted	States
	FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES			13. WAS	DECENDENT OF HISPA	NIC ORIGIN	? (Specify Yea	or No-	14. RACE	- American Indian, White, atc.
	_ ₩	3 Widowed 4 N Olvorced	IF YES, GIVE WAR OR				YES 2 NO Spec		weari, etc.)		Specif	
		15. DECEDENT'S EDUCA	TION	18a. DE	CEDENT'S US	IAL OCCUE	PATION	185	KIND OF BUS	INESS /INF	HICTOV	WIII UG
	ETED	(Specify only highest grade or		(G	ive kind of work Do NOT use re	done during	g most of working	160	KIND OF BUS	INESS/IND	USINT	
.	릴	2-	-	fie	1d te	chn	ician	W	estin	ghou	ıse	
UNCE.	COMPL	17. FATHER'S NAME (First, Middle, Last)					18, MOTHER'S N			_		
ő ,	BE	Roy Fleto	cher				Doris		Sh	ay		
	ဥ	19a. INFORMANT'S NAME (Type/Print)					reet end Number or Rura					
De	-	Tracey Jackson					m Rd., W					21157
18nii		20s_METHOO OF DISPOSITION 1 A Buriel 2 Cremation 3 Remov	al from State Ca	b. PLACE A metery, crp	MD DATE OF D	ISPOSITION place)	N(Name 4/15/ ran Ceme	95 OATI				
		4 Donation 5 Other (Specify)		rını	ty Lu		ran Ceme		l Ta	neyt	own	, MD
		b / · · · ·					itts Fun		Home	& 0	Chap	el
		Katherine 41	itts - Nux	chir		412	2 Washin	gton	Rd.,	Wes	stmi	nster, MD
medical	ĺ	23. PART i. Enter the diseases, or conshock, or heart failure. Li:	mplicationa that cause st only one cause on	d the da	ath. Do not	antar tha	moda of dying, su	ch as card	lac or respi	ratory arr	est,	Approximate interval Between
		iMMEDIATE CAUSE (Final disease or condition	act	10	144.44	700	200	in	don	cha	1/	Onsat and Death
event, me		resulting in death)	DUE TO (OR AS	A COMPE	7000	00	The state of the s		There			minulas
	,		Car An	aru)	and	grus .	Dis	easo	7		yos.
	CERTIFICATION	Sequentially list conditions, if any, leading to immedista	DUE TO (OR AS	A CONSEC	UENCE OF):							1 4
	5	CAUSE (Disease or injury										
		that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEC	DUENCE OF):							
	<u> </u>	d.			-							
		PART II. Other significant conditions	contributing to death	but not r	sulting in t	ha undari	lying cause givan in	Part f.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
	EDICAL	Veripheral	yascula	nd	Lisac	Ludden			PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
	ME	Complete has	J Block	. 5/	PD) [ACIN		J 122 6			OF DEATH?
		DID TOBACCO USE CONTRI	BUTE TO CAUSE C	OF DEA	TH YES	NO	☐ UNCERTA	N 🗆				
1	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEATH (Check only o	one)					
	HYSI	1 TYES 2 THO	☐ Inpatient 2 ☐ ER/Out	patient 3	DOA 4	Nursing I	Home 5 - Residence	-				
1 4	٠.	27. MANNER OF DEATH 1 Neturel 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF		NJURY AT WORK?	28d. DES	CRIBE HOW IN	JURY OCC	CURED	
	<u> </u>	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJUR	Y — At ho	ma, farm etres		YES 2 NO	281 1 00	TION /S	nd About	ne Promit C	Alumba -
1		4 Homicide 8 Could not be determined	building, atc. (Spe	icity)	, contro, miret	., rectory, (ATION (Street a or Town, State)	nu number	or Hural Pic	oute Number,
l i	Ē	29a. CERTIFIER (Check only	AN: To the heat of my keep	vlados 4-	oth occurred -	the sime	date and place and the	a to the				
	COMPL	(Check only one) 2 MEDICAL EXAMINER:										and menner on stated
13	- 11	29b. SIGNATURE AND TITLE OF CERTIFIER		_			29c. LICENSE NU		T T			
	BE I	10810 as	Lan 2				D Z	301	5	29d. DATE	4	Month, day, Year) 12 95
1	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	EATH (ITER	1 27) (Type, Prir	nt)						5 442
		DINESH S. KAI	ARIA &	217	Wits	HINK	ITON HT	617	WES	TMI	NST	EK, my
		APR 1 7 1995 Julia	22. REGISTRAR'S SIGN	ATURE								
1												



STATE REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF OEATN 1995 EDGAR GORE SEWELL 13 April 10:30 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 6. BIRTHPLACE (State or Foreign DAYS HOURS DOXM 2 | F 220-34-9652 YRS. 88 Nov. 6. 1906 U.S.A. (Md Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4761 Ravenwood Rd. Salem Dorchester RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Salem 1 TES 2 THE e executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. In and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. In burial, cremation, or removal. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4761 Ravenwood Rd. 21869 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ ND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 TES 2 ND Specify: BY Specify: white 3 Widowed 4 Divorced 回 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig H Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 Director, Planning & Zoning Office, County gov't. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) ਲ John Gore Ε. Helen Elizabeth Barnett BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Jeanne B. Gore 4761 Ravenwood Rd., Vienna MD 21869 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE Burial 2 Cremation 3 Ren East New Market Cemetery 4/17 4 Donation 5 Other (Specify) New Market Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kenethe Thomas Thomas Funeral Home 700 Locust St Cambridge MD 21613 the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such sa cerdiec or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. intervel Between **IMMEDIATE CAUSE (Fine)** Onset and Death disease or condition Corcorovascular objected reauiting in death) the death certificate be executed within traumatic event, DUE TO (DR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEDUENCE DF): If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events other DUE TO (OR AS A CONSEQUENCE OF): reauiting in deeth) LAST 6 Injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? been signed by th pt. of Health and N shows any 1 YES 2 NO DE DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO DE UNCERTAIN I has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL OR ATTENDING PHYSICIAN: The 26. PLACE OF DEATN (Check only one) DIRECTOR: After this certificate hours after death with the State HOSPITAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Nome 5 Residence 8 - Other (Specily) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation М 1 YES 2 ND BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 91 COMPLETED 6 Could not be 4 Nomicide 28 Hem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL EDGE MINING 72 HIMPORTANT: If II HOSPITAL 2 MEDICAL EXAMINER: On the beals of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 20th, SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 039749 114/95 MO 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G Dutch news 503 Lane Easton 32_REGISTRAR'S SIGNATURE Jalia Stevalson Rardall 9 1995



3. TIME OF DEATH

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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5	A
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	HOSPITAL OR ATTENDING PHYSICIAN: The faw requires that the death certificate he executed within
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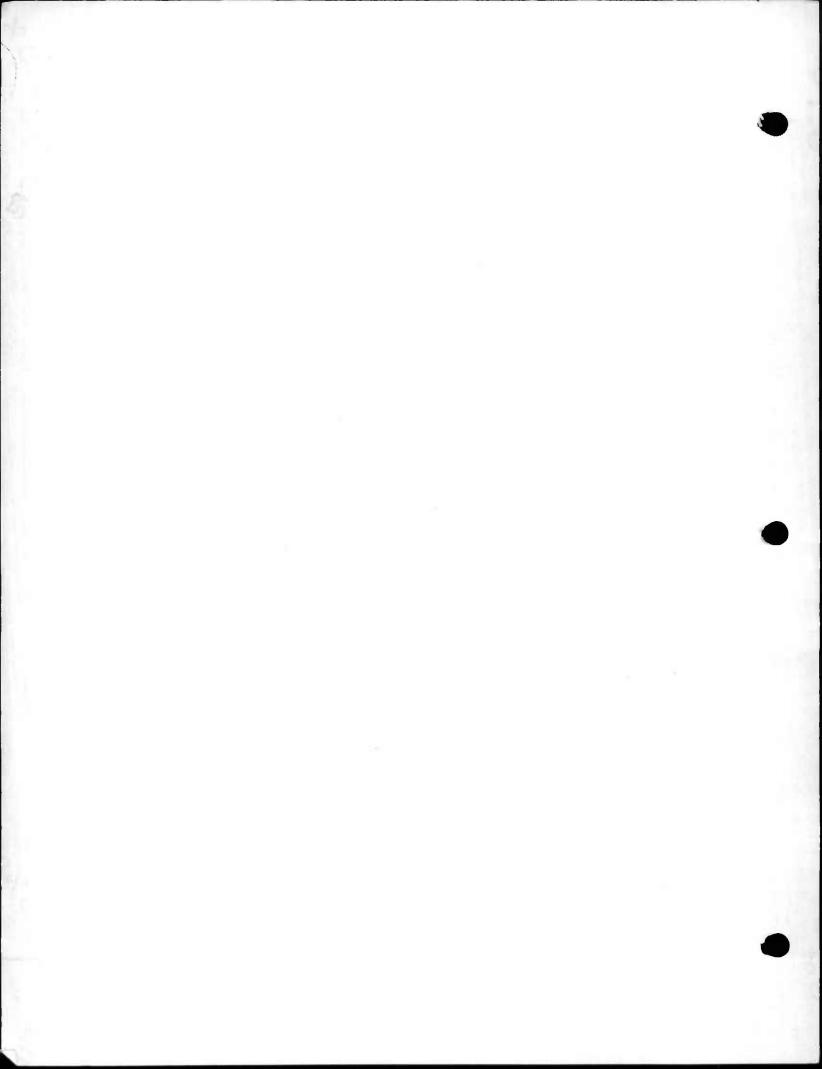
APRIL 16, 1995 SAMUEL GORDON 8:25 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. NOV. 5, 1917 578-22-7953 1 X M 2 - F 77 WASH., permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SHARON NURSING HOME DIRECTOR OLNEY MONTGOMERY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES W NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15301 PINE ORCHARD DRIVE #3H use as the bunal-transit 20906 UNITED STATES retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAS OR DATES 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yee or No—If yee, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION

(Taken kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ATTORNEY/ JUDGE LEGAL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ ISADORE GORDON BE LILLIAN PISNER notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 NITA GORDON (WIFE) 15301 PINE ORCHARD DR. #3H SILVER SPRING, MD 20906 9 20a. METHOD OF DISPOSITION
1A Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must funeral director. 4 Donation 5 Other (Specify) KING DAVID 4-17 FALLS CHURCH, VIRGINIA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. filled in by the fu 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdisc or reapiratory erreat, Approximate shock, or heert fellure. List Dnly one cause on each line. completely filled in rial, cremation, or r intervel Between IMMEDIATE CAUSE (Finel **Onset and Death** the disease or condition MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF): event, resulting in death) in and com to burial, o traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene pror to cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY and I NON-INSULIN DEPENDENT DIABETES MELLITUR shows any been signed of the buth a 1 TYES 2 THO POST-TRAUMATK DEMENTIA 1 - YES 2 - NO PHYSICIAN: certificate has be h the State Dept. d, or item 23 s 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF OEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this c 5 Pending Investigation 1 Natural 1 YES 2 NO After 1 death ВҰ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide TO THE HOSPITAL DR ATTENDIN TO THE FUNERAL DIRECTOR: All be filed within 72 hours after de IMPORTANT: If Item 28 is .00 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide detarmined 29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end menner se stated. 296. SUMMITURE AND TITLE OF CENTRY 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) STAFF PHYSICIAN STAFF PHYSICI 1995 16. 2 20860 HUFFMAN, MD 18100 Slade School Rd. Sandy Spring G, BROOKE MD 31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



pino

DIVISION OF VITAL RECORDS, P.O. BOX 68760

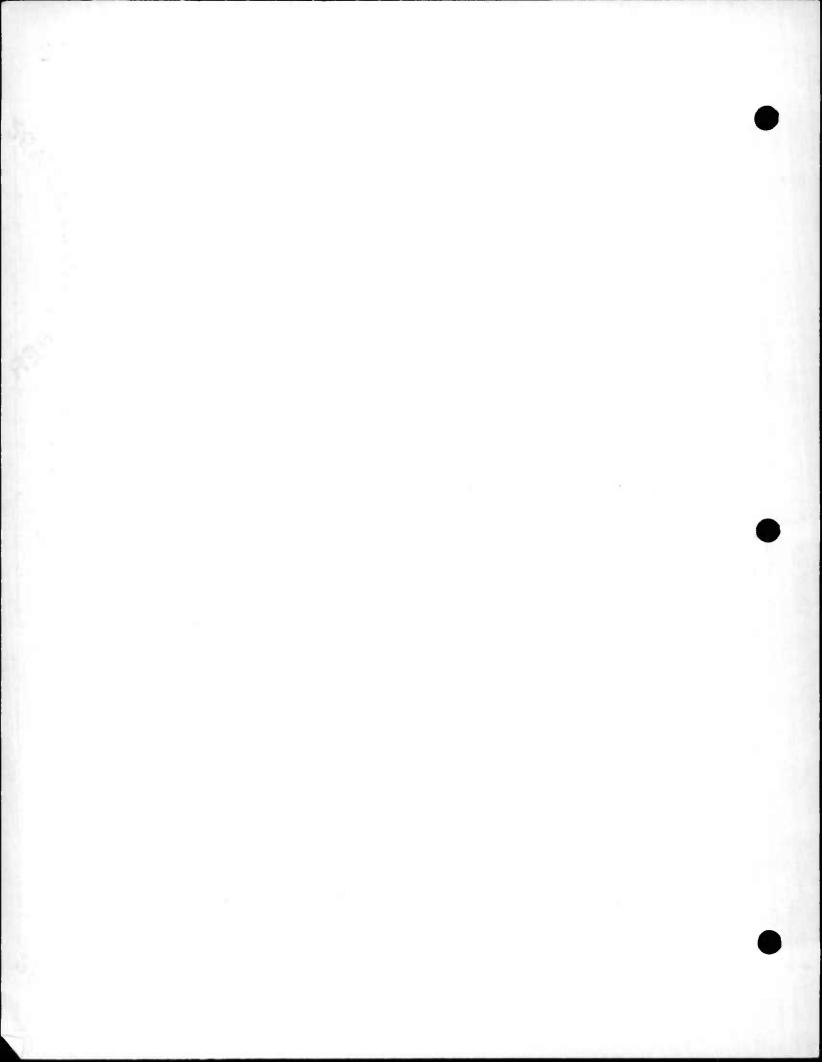
95 13742 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH telen April 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign NOV . 4 1923 097-18-8152 1 M 2 X F 71 NEW YORK 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY BETHESDA 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5225 POOKS HILL ROAD 1812 S. 20814 UNITED STATES 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 KNO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 X Married BY 3 Widowed 4 Divorced WHITE COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) MORRIS KLIGMAN BERTHA COHEN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 HERMAN GLAZER 5225 POOKS HILL ROAD 1812 S. -BETHESDA, MD. 20814 20s. METHOD OF DISPOSITION
1.X Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State KING DAVID MEMORIAL GARDEN 4/17 FALLS CHURCH, VIRGINIA 4 Donation 5 Other (Specify) 21 SIGNATURE OF UNERAL SERVICE LICENSEE DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) CERTIFICATION Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE healt PERFORMED? 1 - YES NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL . 1 TES 2 NO OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF GEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. 26d. DESCRIBE HOW INJURY OCCURED Vetural 5 Pending М 1 YES 2 NO В 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined 29e. CERTIFIER 1 SERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated. 296. SENATURE AND TITLE OF CENTIFIER BE 29c. LICENSE NUMBER

2499 auw AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BIRNS 9711MEDICA Julia Davidson Rend

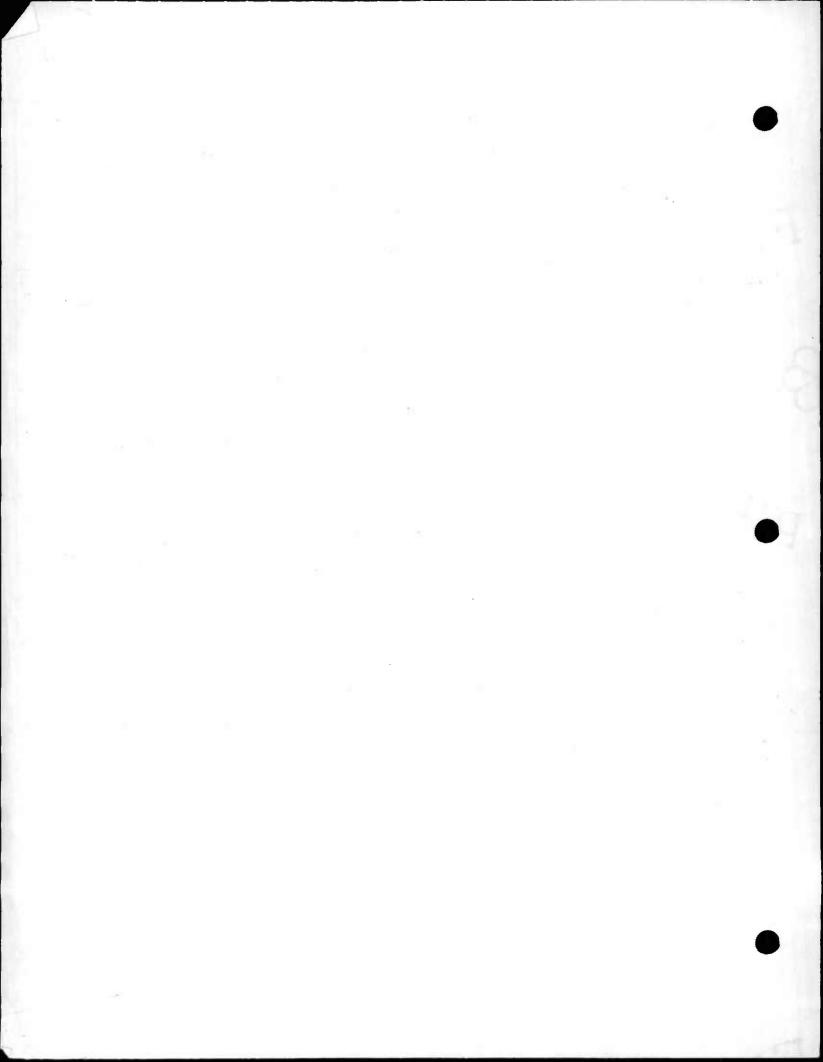
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31. DATE FILED (Month, Day,

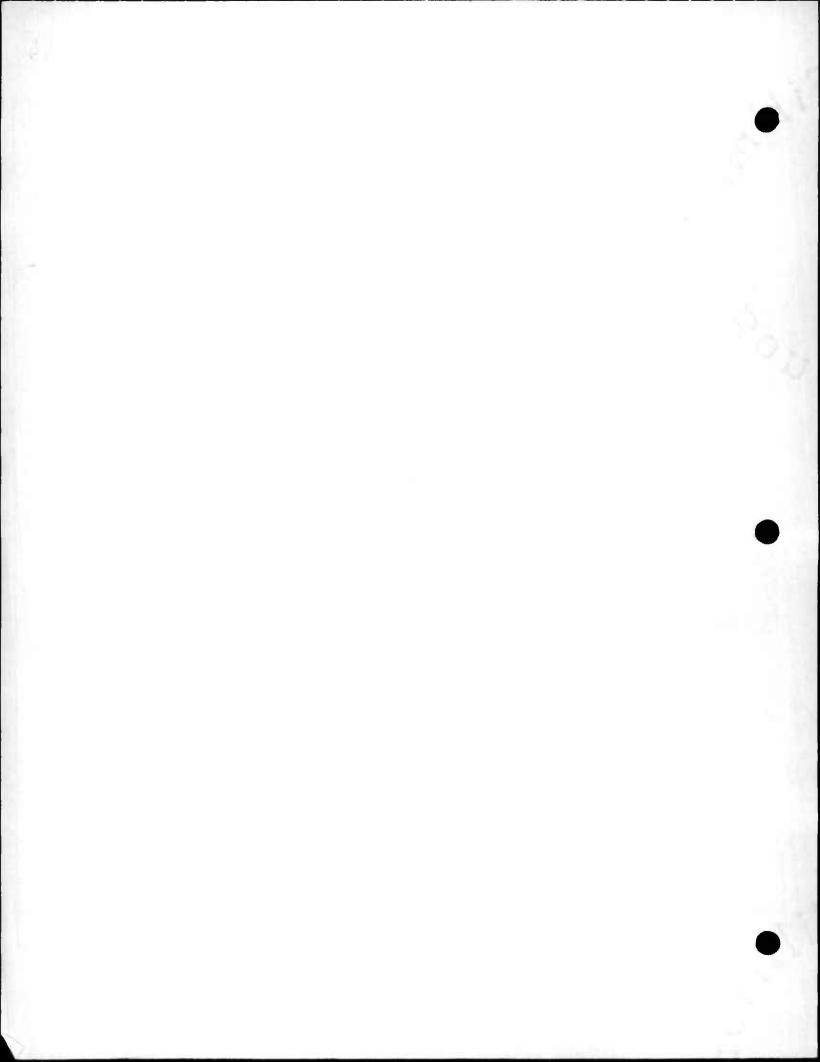
18 1995



		REGISTRAR		CERTI	FICATE O	F DEATH	REG. NO).	
		1. DECEDENT'S NAME (First, Middle, Last)				1.1.	2. DATE OF DEATH	DAY YE	3. TIME OF DEATN
		brace	Virginia		614	115	MONTH .	12 19	71 0345 Am
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	n yrs. last birthday		R IF UNDER 24 HRS.	7, DATE OF BIRTH	8. 8	BIRTNPLACE (State or Foreign
		578-26-7840	1 □ M 2 □XF 77	7 YRS.	MONTHS DAY	8 HOURS MIN,	Dec 24, 1		Maryland
should		9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TOW	N OR LOCATION OF D		9c. COUNTY	
63	E E	Shady Grove Adver	ntist Hosnita	1	Rocky				
2,	15	RESIDENCE OF DECEDENT			Hook	1110		PIOLIC	gomery
Pages	DIRECTOR	10a. STATE 10b. COUNTY		10c. C	TY, TOWN OR LO	CATION			10d. INSIDE CITY
<u>م</u> يخ		Maryland Monto	jomery	Ro	ckville	2			1 X YES 2 NO
permit.	A	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
-ES	FUNERAL	95 Dawson Avenue				20850		Unite	ed States
215-0020 attending physician. se as the burial-transit	S	11. MARITAL STATUS	12. WAS DECEOENT EVER IN		13. WAS E	DECENOENT OF HISPA	NIC ORIGIN? (Specify Ye		RACE — American Indian
P P P		1 Never Married 2 K Merried	FORCES? 1 YES		If yes,	specify Cuben, Mexic (ES 2 NO Specific	an, Puerto Rican, etc.)		Black, White, etc. Specify:
21215-0020 al or attending physic for use as the burial	ВУ	3 Wildowed 4 Divorced					,.		White
atter use a	ETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION (completed)	16a. DECEDENT	'S USUAL OCCUPA	ATION	16b. KIND OF BU	ISINESS/INDUST	RY
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AND 2 the hospital detached to	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden		
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MARYLAND retained by the hospits 5 should be detached notified at once.	9	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIP	O ADDRESS (Street		Route Number, City or Tox		
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BALTIMORE, I er death. Page 6 may be in the funeral director, page 8 val.		200. METHOD OF DISPOSITION	20b.		E OF DISPOSITION			CATION - City	or Town, State
OR may ector, p] [1 Buriel 2X Cremation 3 Remo	vel from State ceme	etery, crematory or			4-15 Be1		
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ALTIN death. Pag tuneral di i. examiner	1 1	11 01	0//	AND THE R.	Rapp	Funeral	Services,	P.A.	
- w = 6	\vdash	10th 151	4	M00827	933	Gist Ave,	Silver Sp	ring, M	1D 20910
E 36 a		23. PART I. Enter the disessea, or co	omplications that ceused list only one ceuse on ea	the death. Do	not entar the r	mode of dying, suc	ch aa cerdiac or reap	iratory arreat,	Approximate
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O. B. ertification ing physical property of their physical property of their pother pother property of their property of			OUE TO (OR AS A	CONSEQUENCE	OF):				
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A and the by the	DICAL	CHRONIC OBSTR					Part I. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
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RECC requires to been signed to the alth shows a	Σ	CONGESTIVE H	EART FAIL	URE,	HYPER	TENSION			1 TES 2 NO
L aw law 23	Z	DID TOBACCO USE CONTR					NE		
OF VITAL RE PHYSICIAN: The law requ this certificate has been i with the State Dept. of H rked, or Item 23 sho	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DE	ATH (Check only or OTHER:	10)			
SICIAN: certific the Si	1 (2)	1 TYES 2 MNO	1 IV Inpatient 2 I ER/Outpa	tient 3 🗆 DOA		ome 5 🗆 Residence	6 Other (Specify)		
OF HYSIC his ce with th	РНҮ	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. T		INJURY AT WORK?	28d, DEŞCRIBE NOW I	NJURY OCCURE	0
ON OF DING PHYSI After this o death with	β	1 Matural 5 Pending 2 Accident Investigation				YES 2 NO			
U 5 4 5	8	3 Suicide 6 Could not be	28e. PLACE OF INJURY - building, atc. (Specif	At home, ferm	, street, fectory, of	ffice	28f, LOCATION (Street City or Town, State)		irel Route Number,
ATTEN ATTEN ECTOR: s after 1 28 1	E	4 Homicide determined					Oily or lown, State)		
OR A DIRECT HOURS	2	29e. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowle	dge, death occu	rred at the time, de	ete end place, end due	to the cause(s) and ma	nner en stated	
PITAL RAL T. II	COMPL		On the basis of examination						see(a) and manner as stated
TO THE HOSPITAL O TO THE FUNERAL D De filed within 72 h		29b. SIGNATURE AND TITLE OF CERTIFIER							
표표표	B	296. SIGNATURE AND TITLE OF CENTIFIER	*4.5			29c. LICENSE NUI		1	NED (Month, Day, Yeer)
₽ ₽ % ₹	2	Todagayala	M.D.			D433	58	APR	11 12,1995
		30. NAME AND AODBESS OF PERSON WHO							
			RS DRIVE,	GER	MANTO	DWN, M	ARYLAN	0 20	874
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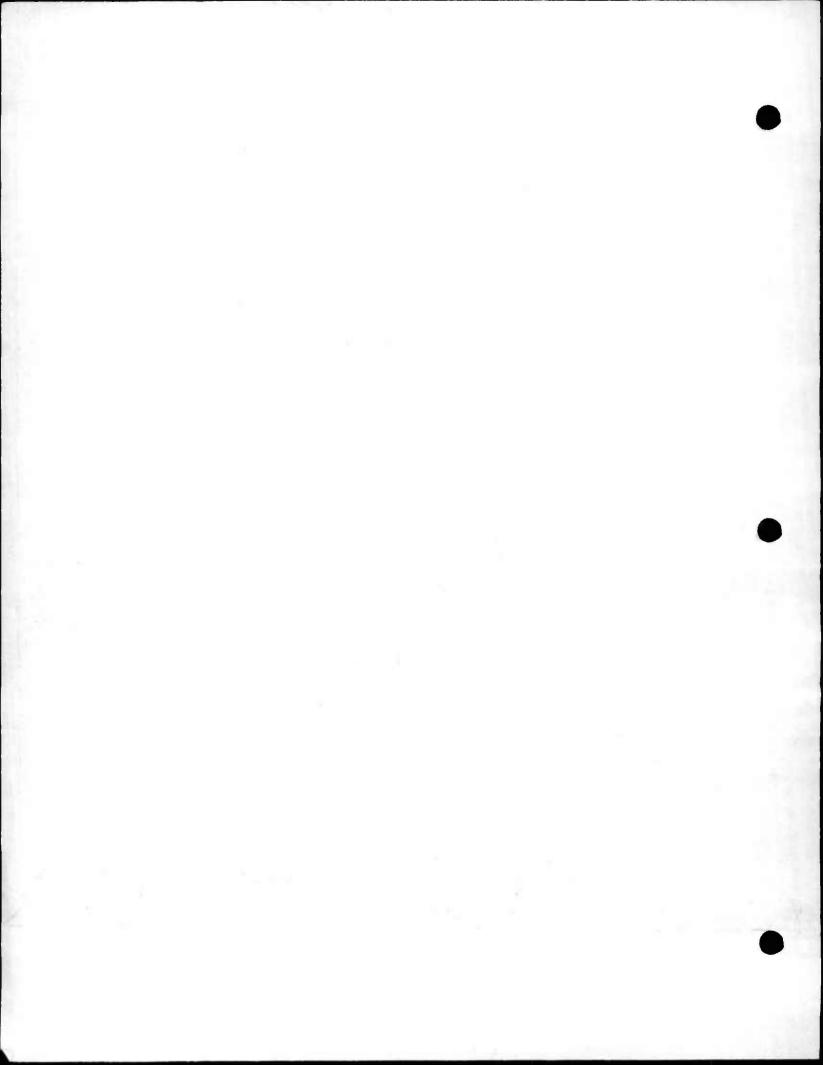


1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH A PONTH 1 2 DAT 1995 YEAR 3. TIME OF DEATH 4:20 A TIFFANY GODBOLT 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. N/A1 M 2 F HOURS April 199\$Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY D.C. Washington 1 YES 2 NO the funeral director, page 5 should be detached for use as the burial-transit permit, 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? #301 501 60th St. N.E. 20019 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TYES 2 NO BY Specify: Specify: BLACK 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Jenkins Tonya Godbolt BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Tonya 60th St. N.E. #301, Wash, DC. Godbolt 20019 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Harmony Memorial Park4/10/95 Landover, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE L 22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th St. N.W. Wash, DC.20010 medicai 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fellure. List only one cause on each line. been signed by the attending physician and completely filled in by xt, of Health and Mental Hyglene prior to burial, cremation, or remo Approximate Interval Between Onset and Death **IMMEDIATE CAUSE (Final** the Previable female (22 weeks gestation) diseese or condition resulting in death) 2 hor event, DUE TO (OR AS A CONSEQUENCE OF): Preruature labor and prom 2 days traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate ceuse. Enter UNDERLYING death certificate be CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2X NO shows a 1 TYES 2 XNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: . OR ATTENDING PHYSICIAN; The law DIRECTOR; After this certificate has bhours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: Item **EXAMINER?** 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 8 8 Could not be 4 Homicide 28 determined COMPLET item 29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. HOSPITAL (FUNERAL D WITHIN 72 h TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If it 2 __ MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end mannar as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D-19142 aion ▶April 2, 1995 enun 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Kerian, MD , 1500 Forest Glen Rd, Silver Spring, MD. Sharon 31. DATE FILED (Month, Day, Year) 32. BEGISTRAR'S SIGNATURE 1995 whi Davidson Rardall



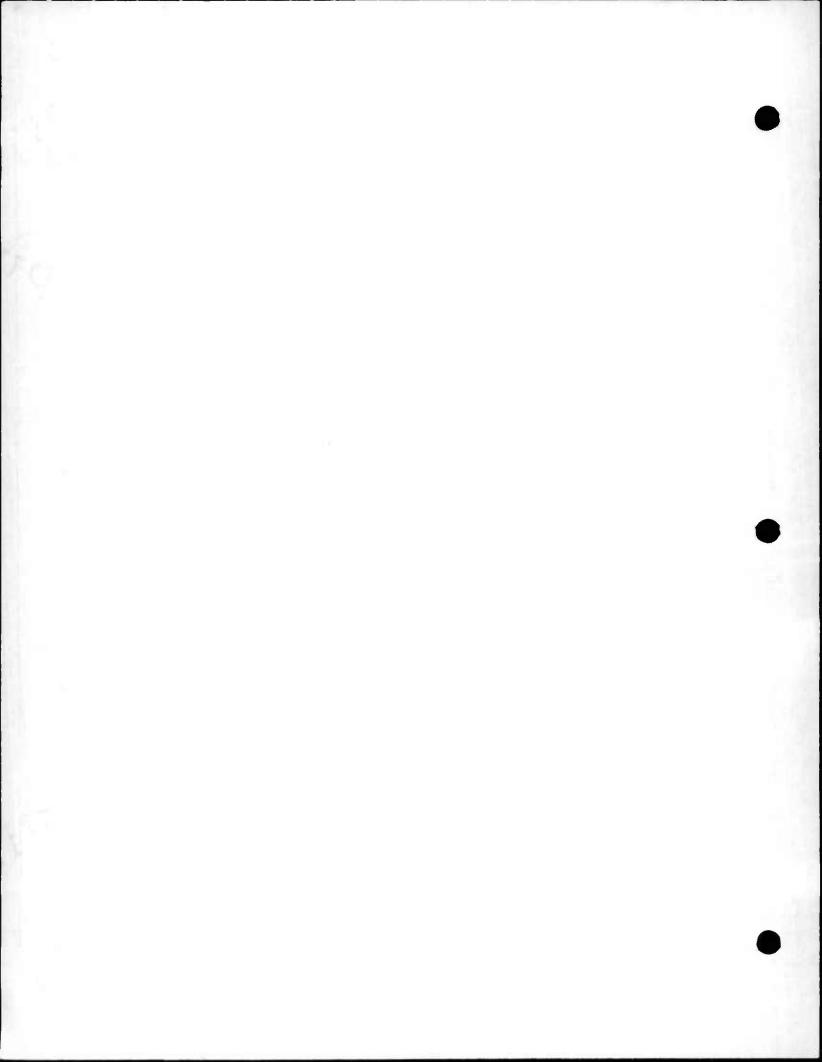
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31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou OIRECTOR: After this certificate has been signed by the attending physician and completely filled focus after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or tem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the m	BE COMPLETED BY PHYSICIAN: MEDICAL	shock, or heart fall IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentlelly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART, II. Other significant cond DID TOBACCO USEICO 25. WAS CASE INFERENCE DI MEDICE EXAMINERT 1 YES 2 700 27. MANNES C DEATH 1 Natural 1 Pending Immediate 29a. CERTIFIER (Chich only only 2 MEDICAL EXA	Bitions contributing to the part of the pa	GOR AS A CONSECUTION OF INJURY AT HE SECUTION	DUENCE O	FI: FI: FI: FI: FI: FI: FI: FI: FI: FI:	THE PROPERTY OF THE PROPERTY O	given in ERTAIN Beldence In and due red at the ENSE NUM	Part I. 24a. WAS AN PERFOR I VES 2 I Other (Specify) 28d. DESCRIBE HOW I City or Xwe, State) to the cause(e) end mer time, date and place, end ABER	AUTOPSY INCOME INJURY OCC INDUSTRIAL IN	24b. W	Interval Between Onset and Death Trains Hard Hard Hard Hard Hard Hard Hard Hard
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		1 - FOR STATE REGISTRAR		STATE OF I	MARYLAN				TEALTH AN	D MEN	TAL HYGIEN			
		1. DECEDENT'S NAME (First	,	. /	7		TOA. L	<u> </u>	DEMI		DATE OF DEATH	IV.	VEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUME		A C	RAV					A	PRIL 1	6	15	1.50 PM
		578-26-427	7	1 🗆 M 2 🗓 💢		88 YRS.		AYS	HOURS MIN	M	Month, Day, Year) ay 11, 1		Mar	yland
i	CTOR	99. FACILITY NAME (# not in Laurel Reg	ional	treet and number) Hospital	L		96. CITY, TO Lau		OR LOCATION OF	F DEATH			NTY OF DE	eorge's
	EG	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCAT	TION					10d. INSIDE CITY
	L DIRE	Maryland 100. STREET AND NUMBER		ce Georg	ge's	Ве	eltsvi		E 1. ZIP CODE			100 CIT		LIMITS? 1 YES 2XXNO HAT COUNTRY?
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	BY FUNE	11. MARITAL STATUS 1 Never Married 2 3 Never Married 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	X NO	13. WA	S DEC	CENDENT OF HIS ecity Cuben, Me 22 NO Sp	PANIC Oi xicen, Pu ec/ly:	RIGIN? (Specify Yee erto Rican, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, alc. White
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at unce.		17. FATHER'S NAME (First, M William A		1 1							irst, Middle, Malden	Surneme)		
Dalling) BE	19e. INFORMANT'S NAME (7	ype/Print)	all		19b. MAILING	ADDRESS (S	itreet a	Verqi	e N	1. Hughe Number, City or Town	es n, State, Zip	Code)	
De not	욘	John F. Gr				4913	Musk	oge	ee					land 20740
must		20a METHOD OF DISPOSITE A Donation 5 Other	ION in 3 Remi	oval from State	20b.PL.	ACE AND DATE OF PARTY	of DISPOSITION	ON (Na	ame of	-:120	,1995 Ade	CATION —	City or Tow	n, State
	į	21. SIGNATURE OF FUNERA		ENSEE	COL	ge wasiii	22. NAI	MF AN	NO ADDRESS OF	FACILITY	Υ			
examiner		· NOVal	al V.	Sorga	Jarol	t-	440	0 E	Powder	Mil1	rdt Fund Rd. Bei	ltsvi	11e,	, P.A. Md. 20705
event, the medical		23. PART I. Enter the dishock, or he iMMEDIATE CAUSE (Find disease or condition resulting in death)	eert tellure.	List only one cau	ise on each	ilne.	ot anter the	e mo	de of dying, a	uch as	cardiac or reapl	ratory an	rest,	Approximate interval Between Onset and Death
	Ì	resorting in death)		DUE TO	(OR AS A CO	ONSEQUENCE OF	P): , -							1-1/
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2 I .	COMPL				kamination en	d/or investigatio	n, in my opini	lon, de	eath occured at	the time,	date end place, end	d due to th	e ceuse(e)	end manner se stated.
Zun'i	BE	29b. SIGNATURE AND TITUE	OF CERTIFIER	inter	M	0			29c. LICENSE I	NUMBER	,	29d. DATE	SIGNED (Month, Day, Year)
2	٩	30. NAME AND ADORESS OF	PERSON WHO	COMPLETEO CAUS	SE OF DEATH	(ITEM 27) (Type,	Print)	,	0 1	06	24006	4	100	-75.
	ŀ	31. DATE FILED (Month, Day, APR 2		32. TEGISTAN	S JENAY	Boolsh	1000		120		everly	,4	Ua	070 0
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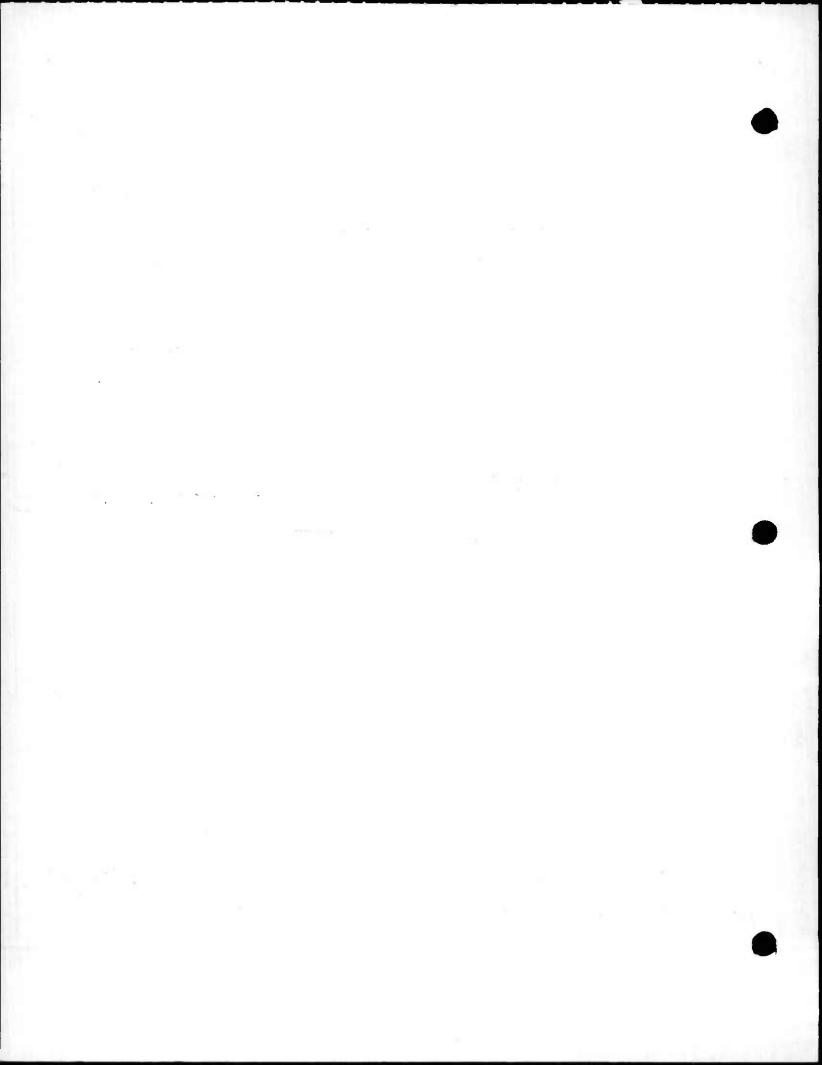
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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_	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF H	EALTH AND	MENTA	L HYGIEN			
1	1. DECEDENT'S NAME (First, Middle, Last) DENNIS JO	SEPH GRETZ				MDN	OF DEATH		YEAR	3. TIME OF DEATH P M
	187-32-2671	1 🔀 M 2 🗆 F 5		FUNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon	of BIRTH th. Day, Year)		Country	PLACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give stre NATIONAL NAVAL M RESIDENCE OF DECEDENT				ESDA	EATH			ONTGO	OMERY
DIRECTOR	Maryland Montg	omery	Whea	OWN OR LOCAT	IDN					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	11613 College Vie			2	. ZIP CODE 0902			Unit	ced S	hat country? States
B⊀	1 Never Merried 2 Married	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D. U.S.M.C.	2 NO	If yes, sp	ENDENT OF HISPA ecify Cubsin, Mexica 2 X NO Specif	en, Puerto	N? (Specify Yes Ricen, etc.)	or No-	14. RACE Black, Specify	— American Indian, White, atc. White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	TION Impleted) Cotlege (1-4 or 5 +)	18a. DECEDENT'S US (Give kind of work life. Do NOT use re	UAL OCCUPATION done during months.)	ON st of working		E. KIND OF BUS			
COMI	17. FATHER'S NAME (First, Middle, Lest) Frank Ferdina		Manager z		18. MOTHER'S NA			Sumame)	npins	:ki
TO BE	19a. INFORMANT'S NAME (Type/Print)	ife)			nd Number or Rural	Route Nun	nber, City or Tow			JKI.
	20a. METHOD OF DISPOSITION 1	al from State	PLACE AND DATE OF DELECT CONTROL OF CONTROL	place)		4-1	l9 Bet	hesda		
	21. SIGNATURE OF FUNERAL SERVICE LICER	Ph	M00827	Rapp 933 G	Funeral ist Ave,	Serv Si]	vices, Lver Sp	P.A.	, MD	20910
	23. P(F) i. Entar tha diseases, or conshock, or heart failura. Li iMMEDIATE CAUSE (Final disease or condition resulting in death)	METAST	ATIC LUNG		da of dying, suc	th as car	diac or respi	ratory arre	est,	Approximate interval Batween Onset and Daath 4 years
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST		CONSEQUENCE OF):							
MEDICAL O	PART ii. Other aignificant conditiona	contributing to death b	ut not raaulting in t	ha undarlying	cause given in	Part i.	24a. WAS AN PERFOR 1 TYES 2	MED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO
PHYSICIAN: N	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)	UNCERTAIL	N 🗆				
IXSI		Inpetient 2 ER/Outp	atient 3 DOA 4		5 🗆 Residence					
BY PF	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	M 1 1	RK? ES 2 NO	28d. DE	SCRIBE HOW II	NJURY OCC	URED	
ETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— Al home, farm, atres	nt, factory, office		281. LOC City	ATION (Street a or Town, State)	nd Number (or Rural Ro	oute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIA EXAMINER:									and manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	mer A	ATH OTHER AT		29c. LICENSE NUR	0362		10	7 AF	Month, Day, Year)
	M. ZUHDT JASSER L 31. DATE FILED (Month, Day, Year)			<i>K)</i>	NATIONA BETHESD			DICAL 9-560		TER
	NDD 21 1995 Jul	La Davidson Ran								i



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

HEGISTHAN		C	ENTIFIC	CAILO	F DEA	I II	REG. NO			
1. DECEDENT'S NAME (First, Middle, Las	st)						2. DATE OF DEATH	AY	YEAR	3. TIME OF DEATH
MA	DELINE	M .	GA	NNON			April 4	. 19	95	1:12 PM
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEA		R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		a. BIRTHP	LACE (State or Foreign
157-01-1103	1 🗆 M 2 💯 F	74	YRS.	MONTHS DAY	S HOURS	MIN.	11/9/19	20		Jersey
9a. FACILITY NAME (If not institution, give	e street end number)			9b. CITY, TOW	N OR LOCAT	ION OF DE			NTY OF DE	
1226 Rid	ge Road				Pvle	etri '	110		Hor	rford
RESIDENCE OF DECEDENT	go moau				T. Y T. C	DY J.	116		nai	TOPU
10a. STATE 10b. COU	NTY		10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY LIMITS?
Maryland	Harford				P	vle	sville			1 YES 2 NO
10e. STREET AND NUMBER					10f. ZIP COD	4	7 2 2 2 0	10g. CIT	IZEN OF W	HAT COUNTRY?
1226	Ridge R	oa.d				271	32		TT S	.A.
11. MARITAL STATUS	12. WAS DECEDEN	EVER IN U.S. AF	MED	13. WAS 1	DECENDENT	OF HISPAI	VIC ORIGIN? (Specify Ye	s or No-		- American Indian, White, etc.
1 Never Merried 2 Merried	FORCES? 1 IF YES, GIYE W		NO	If yes,	specify Cub	en, Mexico	n, Puerto Rican, atc.)		Black, Specify	
3 Widowed 4 Divorced				1	A	ороси	,.		494	casian
15. DECEDENT'S E		16e. DE	CEDENT'S U	ISUAL OCCUP	ATION		16b. KIND OF BU	SINESS/IN		100000000000000000000000000000000000000
(Specify only highest gri	College (1-4 or 5 4	116	Do NOT use	ork done during retired.)	most or work	ing				
10			Но	usewi	fe			Ho	me	
17. FATHER'S NAME (First, Middle, Last)			-10	The state of the s		HER'S NA	ME (First, Middle, Meider		211.0	
	pencott	Gann	on				tta Flo		A T	Rowlev
19a, INFORMANT'S NAME (Type/Print)	policood			ADORESS (Stra			Route Number, City or Toy			OMTEA
Loretta R. W	inlel on		o, motalite .				riodic riombei, only or lor	711, Giaio, 24	p 0000)	
200 METHOD OF DISPOSITION	THYTET.	200 01 405	OF DISPOSI	Same			I a			
1 A Buriel 2 Cremation 3 R R	emoval from State	Beth	(ece)			matory or			City or Tov	
4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	LIGHTER O	I Be th	ет о	emete			4/1 Hu	riiv	71116	e, N.J.
100 1/1	1	V.		K	urtz	Ful	cium neral Ho	me		
1 11. Klark	len Tust	6-10					ville, M		and	
23. PART I. Enter the diseases, o	or complications the	ceused the de	eath. Do no							Approximate
23. PART I. Enter the diseases, o shock, or heart failur	ne. List only one cat	ae on eech line	D.	Alt Storage					,	interval Between
iMMEDIATE CAUSE (Final disease or condition			c 1.	1101						Onset and Deeth
resulting in death)	a	LUN		LEI						5 Mos.
ľ	DUE TO	(OR AS A CONSE	OUENCE OF):						/
Sequentially list conditions.	ь				_					
if any, leading to immediate cause. Enter UNDERLYING	DUE 10	(OR AS A CONSE	OUENCE OF)):						
CAUSE (Diseese or injury	C									
that initiated events resulting in death) LAST	DUE 10	(OR AS A CONSE	OUENCE OF):						
rossiang in docum, exo.	d									
PART II. Other aignificant condit	ions contributing to	death but not	resulting Ir	the underly	ving cause	given in	Part I. 24s, WAS AI	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
					,		PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
·							1 □ YES	2 X NO		OF DEATH?
										1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				. PLACE OF	DEATH (Ch	eck only one)			
1 TYES 2 NO	1 Inpatient 2	ER/Outpatient		OTHER: 4 Nursing I	lome 5 X F	lesidence	6 Cher (Specify)			
27. MANNER OF DEATH	26s. DATE OF (Month, D		28b. TIME		INJURY AT WORK?		26d. DESCRIBE HOW	INJURY OC	CCUREO	
1 Natural 5 Pending 2 Accident Investigation		,,,			YES 2	□ NO				
3 Suicide 6 Could not	28e. PLACE O	F INJURY — At h	ome, farm, st	reet, factory, o	office		261. LOCATION (Street		er or Rural R	oute Number,
4 Homicide determined		atc. (Specify)					City or Town, State	"		
29e. CERTIFIER 1 CERTIFYING PH	VOICIAN: To the bear of	mu knamta 4 4	anth and	d as st- s	detailed at the		alia. La como de la co	STEE CHE		
	YSICIAN: To the bast of									
	IINER: On the baels of a	ANTHERINA POG/OF	"Wasildatiou	, in my opinio	n, death occi	ured at the	time, date end place, e	nd due to t	me cause(e)	eng manner se stated.
29b. SIGNATURE AND TITLE OF CERTI	FIER	1000		love 4		ENSE NU	MBER	29d. DA	TE SIGNED	(Mohin, Day, Year)
6+.W	-111	GARY		/	0 9:	277	3 0		4/1-	175
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAU	BE OF OEATH (ITE	M 27) (Type,	Print)		1		,		
6569 N. CH.	ANUET ST	. /	AUTI	Love	1	<i>P</i> .	21204			
31. DATE FILED (Month, Day, Year)	32 REGISTRA	R'S SIGNATURE								
MAKT \$ 188	5 Julia de	webson Ra	dall							

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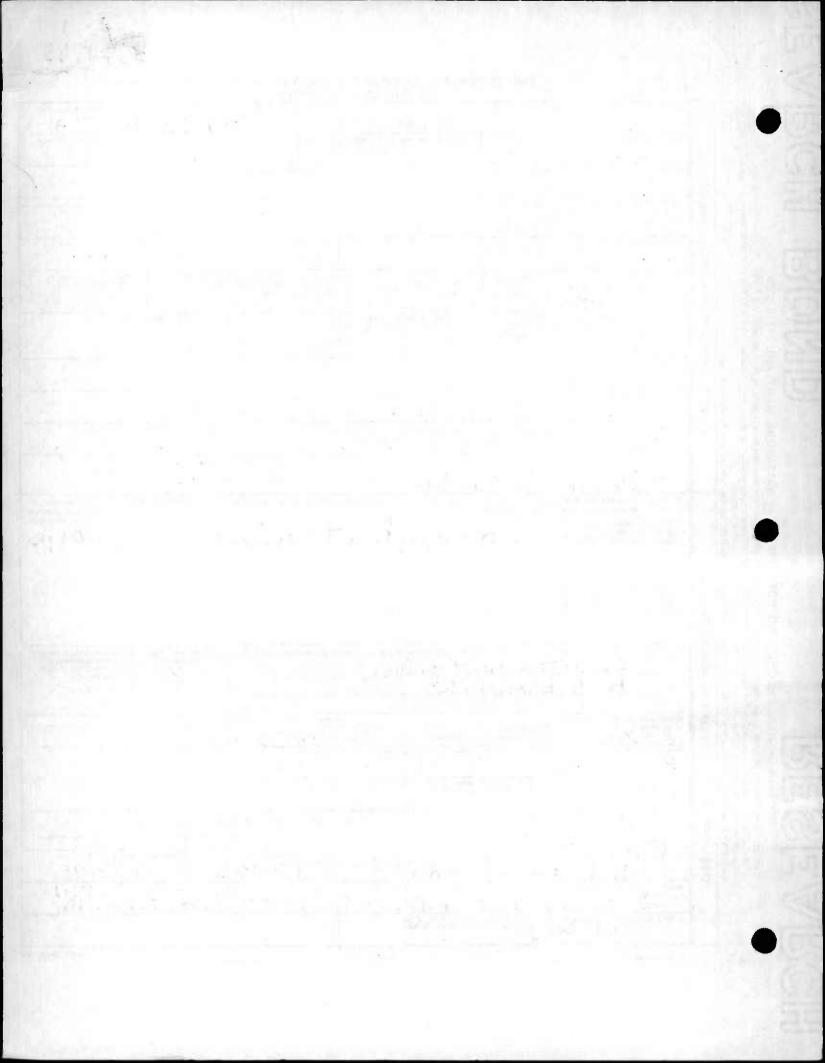
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A. Carrier and Car

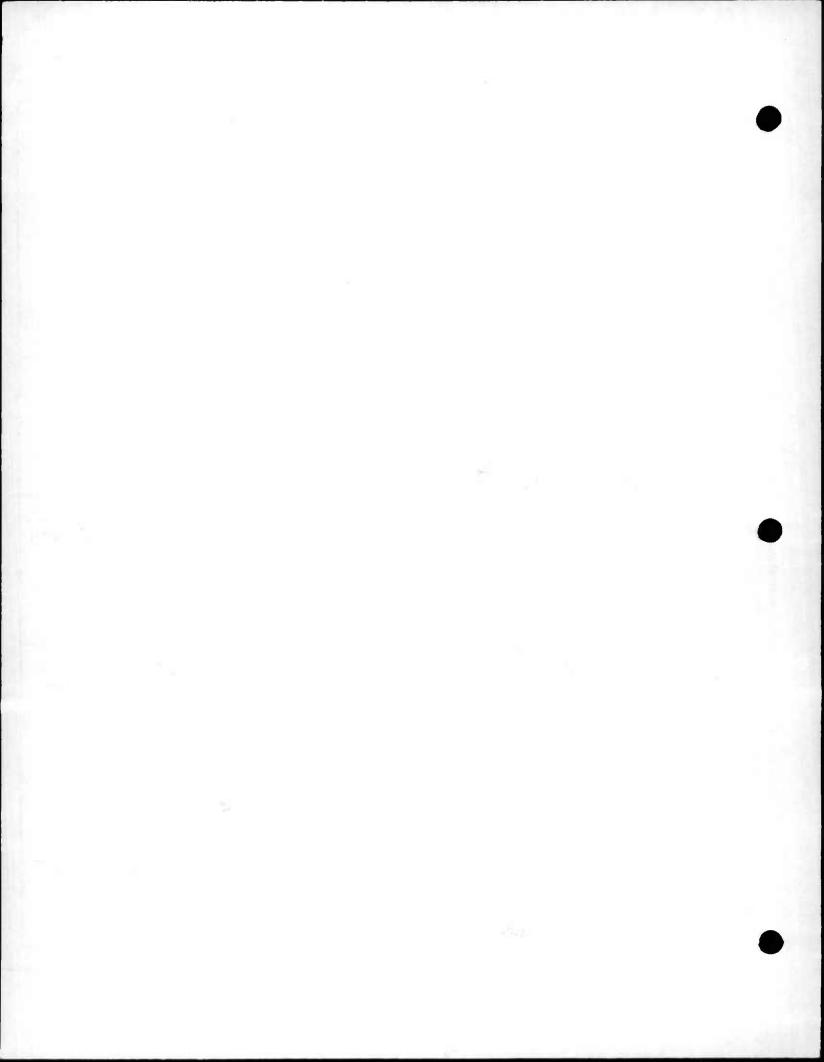
BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1	1. DECEDENT'S NAME (First, Middle, Las		CERTIFI	CATE OF DEATH	REG. I				
	JAMES		RBER		2. DATE OF DEATH	PM 3	3. 1	7 A	
	4. SOCIAL SECURITY NUMBER 219-16-0574	5. SEX 6. AGE	(In yrs. lest birthday) 82 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	Miles the Charles	1912	6. BIRTHPLA	CE (State or Foreign LAND	
E C	9e. FACILITY NAME (If not institution, give	atreet and number)		96. CITY, TOWN OR LOCATION OF UNION BRIDG	OEATH	9c. COUNT	RROLL	4	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	CARROLL		TOWN OR LOCATION ION BRIDGE				I. INSIDE CITY LIMITATES YES 2 NO	
	100. STREET AND NUMBER 3 W. BROADWAY	ARKKO ELE		101, ZIP CODE	1791	10g. CITIZI	EN OF WHAT		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed And Dispraced	12. WAS OECEDENT EVER FORCES? 1 YES	S 2 NO	13. WAS DECENDENT OF HIS If yes, specify Cuban, Mex	PANIC ORIGIN? (Specify			American Indian, hite, atc.	
COMPLETED	17GT TEU 15. DECEDENT'S EC (Specify only highest gra Elementary/Secondary (0-12) 1 1	UCATION		USUAL OCCUPATION ork done during most of working pretired.)	18b, KIND OF	BUSINESS/INDU	STRY	1111	
_	17. FATHER'S NAME (First, Middle, Last) EDWARD THOMAS (GARBER	0.114 2.11	18. MOTHER'S	NAME (First, Middle, Make, ENI GRAY R	den Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print) HELEN P. GARBEI	}		ADORESS (Street and Number or Rus BROADWAY	rel Route Number, City or UNION BRI	Town, State, Zip (Code) MD	21791	
= 100	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	BURLAL 24 movel from State co	Ob. PLACE AND DATE Of	AND DATE OF DISPOSITION (Name of PE CREEK CEMETERY 4/15 NR. NEW WINDSOR, I					
	23. PART I FIRE the diseases	O. Lai	blen		ON BRIDGE,	MD	12LEK	& SONS	
	shock, or heart failure	. List only one cause or	ed the death. Do n each line.	ot enter the mode of dying, a		apiratory arre	at,		
ERTIFICATION	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	reant du		apiratory arre	at,	Interval Betwe	
MEDICAL CERTIFICATION	shock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF	reant de	in Part I. 24a. WAS	AN AUTOPSY FORMED?	24b. WEF	Approximata Interval Betwee Onset and Date Onset and Date Onset and Date Onset and Date Onset on Onset	
MEDICAL	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST PART II. Other significant conditions EXAMINER?	a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF	teast duspite de la constant de la c	In Part I. 24a. WAS PERI	AN AUTOPSY FORMED?	24b. WEF	Interval Between Onset and Dail Conset and Dai	
PHYSICIAN: MEDICAL	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in desth) LAST PART II. Other significant conditions EXAMINER? 1 YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH Neturel 5 Pending	a. DUE TO (OR AS b. DUE TO (OR AS d. DUE TO (OR AS d. DOS CONTributing to death HOSPITAL: Inpetiant 2 ER/Out 28a. DATE OF INJURY (Month, Dey, Year)	A CONSEQUENCE OF A CONSEQUENCE OF but not resulting in particular and DOA 28b. Time	28. PLACE OF DEATH OTHER: 4 Nursing Home Resident OF 28c. INJURY AT WORK?	In Part I. 24a. WAS PERI	AN AUTOPSY FORMED?	24b. WEF AWA CON DF	Interval Between Onset and Dail Conset and Dai	
ED BY PHYSICIAN: MEDICAL	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in desth) LAST PART II. Other significant conditions EXAMINER? 1 YES NO 27. MANNER OF DEATH	B. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF A CONSEQUENCE OF A CONSEQUENCE OF but not resulting in ripetient 3 □ DOA 28b. Time RY — At home, farm, s	28. PLACE OF DEATH OTHER: 4 Nursing Home Resident OF 28c. INJURY AT WORK? M 1 YES 2 NO	in Part I. 24a. WAS PERI 1 YES (Check only one)	AN AUTOPSY FORMED? 5 2 NO	24b. WEF	Interval Betwo	
BY PHYSICIAN: MEDICAL	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not b determined 29e. CERTIFIER (Check only) CERTIFYING PHY	DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (OR A	A CONSEQUENCE OF A CONSEQUENCE OF A CONSEQUENCE OF Dut not requiting in A consequence of A consequence of A consequence of A consequence of A consequence of A consequence of A consequence of A consequence of	28. PLACE OF DEATH OTHER: 4 Nursing Home Resident OF 28c. INJURY AT WORK? M 1 YES 2 NO	in Part I. 24s. WAS PERI 1 YES (Check only one) 26d. DESCRIBE HO 28f. LOCATION (Street, Str	AN AUTOPSY FORMED? 2 NO W INJURY OCCL wet and Number of stell manner as states	24b, WEI AMA CON DF 1 1	Interval Betwoonset and Da 2D + 4 A Reautopsy Finding Lable Prior to Meletion of Causto Death? Yes 2 No Number,	



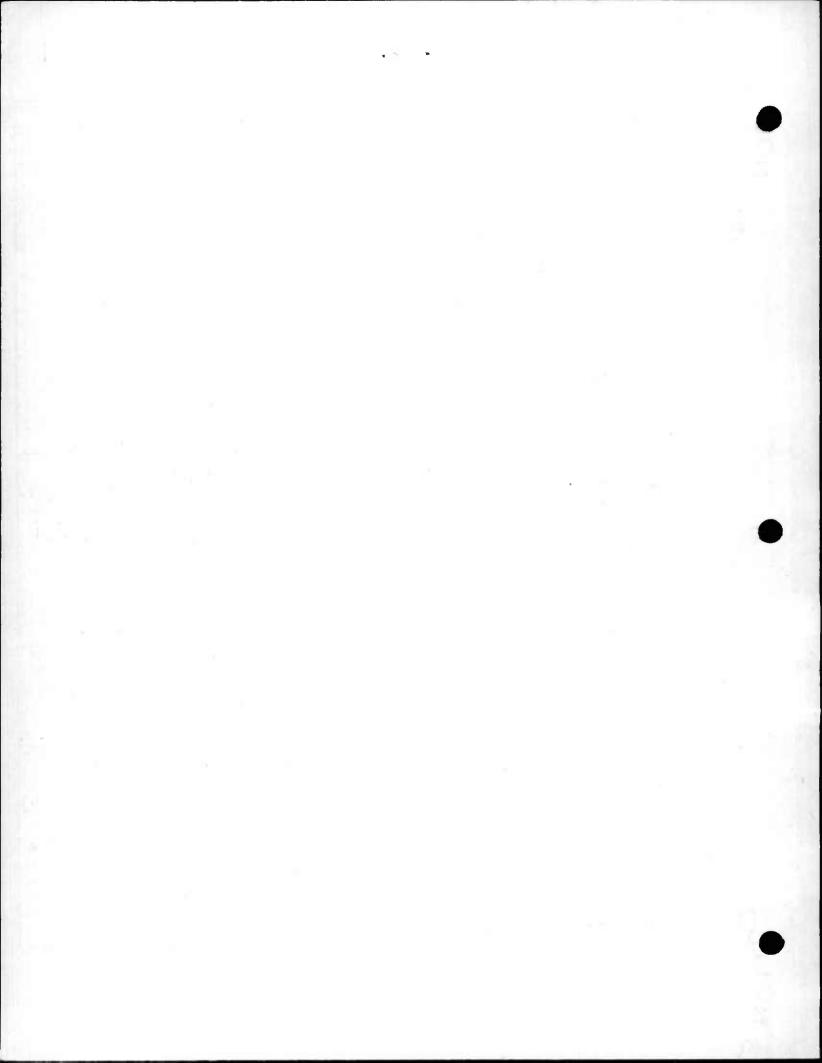
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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF	HEALTH AND	MENTAL	HYGIENE REG. NO.		
		DECEDENT'S NAME (First, Middle, Last)	VIRGINIA	Ε.	HUFFM	AN	2. DATE O MONTH April	DAY	995	3. TIME OF DEATH 7:40 a m
PI		4. SOCIAL SECURITY NUMBER 219-76-1308	1 □ M 2 💢 F 81	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		BIRTH Day, Year) 18 1914	8. BIRT Coun	HPLACE (State or Foreign try) W.VA.
1, 2, 3 should	TOR	9a. FACILITY NAME (# not institution, give str MEMORIAL HOSPIT RESIDENCE OF DECEDENT			CUMBER	OR LOCATION OF O	DEATH		OUNTY OF I	
Pages	DIRECTOR	10a. STATE 10b. COUNTY	LEGANY		V, TOWN OR LOCA					10d. INSIDE CITY LIMITS? 1XXYES 2 \(\square\) NO
n. ansit permit.	FERAL	100. STREET AND NUMBER 815 OLD TOWN ROAI)		10	21502			U.S.A	WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 📉 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 7 NO	If yes, a	CENDENT OF HISPA pecify Cuban, Maxico S 2 NO Specia	an, Puerto Ric	(Specify Yea or No-	- 14, RAC Blac	E — American Indian, ck, White, etc.
5 5	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATI work done during m se retired.)	ON ost of working	18b. K	IND OF BUSINESS	INDUSTRY	
oy the hospital be detached to at once.	COMPL	8 17. FATHER'S NAME (First, Middle, Last)		HOUSE	KEEPER	18, MOTHER'S NA		HOUSE KE		
MAR retained to 5 should	TO BE	SAMUEL S. SUNDERI 190. INFORMANT'S NAME (Type/Print) MARION WILLIAM HU				BERTHA	Route Number		in a	01500
Page 6 may be ral director, page liner must be		20e. METHOD OF DISPOSITION 1 Spurish 2 Cremetton 3 Remo 4 Donation 8 Other (Specify)	val from State 20b. F	PLACE AND DATE	OF DISPOSITION (N		DATE	20c. LOCATION	— City or To	21502 own, State
A L Jeath fune tune		21. SIGNAPHIE OF PUNERAL SERVICE SICE	Mart		MERRI'	ND ADDRESS OF FA TT-ADAMS ECATUR ST	FUNER	AL HOME		
within 24 within 24 pletely fill cremation, rent, the		23. PART I. Enter the disease, or conshock, Dr. heart failure. L. IMMEDIATE CAUSE (Final disease Dr. condition resulting in deeth)	interpolations that caused ist only pre-cause on each	1/50	not enter the me	Ode of dying, aud	ch as cardia	c or respiratory	nrest,	Approximate interval Between Onset and Death
C. BOA ba certificate be execu- ling physician and o griene prior to burn other traumation	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C							
at the deat by the atte and Mental y Injury,	MEDICAL CEI	PART II. Other significant continues	controuting to death bin	suiting i	n the underlyin	g cause given in		Ia. WAS AN AUTOPS PERFORMED? YES 2 MO		D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PM
AL K le law rec has beer Dept. of	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	20		S NO I		N 🗆			1 123 2 2 10
	PHYSIC	1 TES 2 ND 27. MANNER OF DEATH	HOSPITAL: 1 W Inpatient 2 ER/Outpat 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, IN.	Ne 5 Reeldence		Specify)	CCURED	
NDING R: After or death is man	ED BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY — building, etc. (Specify	- At home, ferm, s	M 1 🗆	YES 2 ND	28f. LOCATI City or	ON (Street and Numb Town, State)	per or Rural i	Route Number,
AL OR AL DIRI	COMPLET	290. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my knowled							
TO THE HOSPITAL TO THE FUNERAL Be fied within 72 h IMPORTANT: If I	w I	29b. SIGNATURE AND TO F OF CERTIFIER	On the basis of examination a	and/or investigatio	n, in my opinion, o	leath occured at the 29c, LICENSE NUI			-	o) end manner as stated.
5 5 3 X	10 B	30. NAME AND ADDRESS OF PERSON WHD				D 1604		/	Jam	11,1995
4		Dr. Terry William 31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNAT		Medical	Buildin	.g-Cuml	perland,	MD	21502
		APR 1 2 1995	- Kila Marie	- MANDAM						DHMH-18 Rev 1/89



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
TARRAMENTAL CONTRACTOR OF THE PARTY OF THE P	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	20						9	5	3751
	1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF CATE OF		MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH MONTH	AY	4545	3. TIME OF DEATH
	VERNON	V.		MBERSO	N		14	95	8:02A M
i	215-20-5598	☑ M 2 □ F 71		IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) Mar 19, 1	924	(Country)	LACE (State or Foreign Sylvania
DIRECTOR	98. FACILITY NAME (If not institution, give street 1637 Old Morgantov route 1 Box RESIDENCE OF DECEDENT	wn Rd., West	t,		OR LOCATION OF DE			UNTY OF OEA	
REC	10a, STATE 10b, COUNTY		10c. CITY	, TOWN OR LOCA	TION				IOd. INSIDE CITY
	Maryland Garret	t	Fri	endsvi1					LIMITS?
FUNERAL	1637 Old Morgantow			16	21531			TIZEN OF WA	IAT COUNTRY?
B₹	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 To Divorced	FORCES? 1 TYPES IF YES, GIVE WAR OR DAT WWW 2	2 NO	If yea, s	CENDENT OF NISPANI pecify Cuban, Maxican S 2 1 NO Specify:	C ORIGIN? (Specify Ye., Puarto Rican, etc.)	or No-	14. RACE Black, Specify Whi	
COMPLETED	15. DECEDENT'S EOUCATI (Specify only highest grade com Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5 +)	16a. DECEDENT'S L (Give kind of w life. Do NOT use	JSUAL OCCUPATI ork done during m retired.)	ON ost of working	18b, KIND OF BU	SINESS/IN		rce
MPL	12 th		Disabled	Vetera	n	Disab1	ed		
BE CO	17. FATHER'S NAME (First, Middle, Last) Fred Humberson				LaWand	NE (First, Middle, Malden la Knapp			
2	Bruce F. Humberson		196. MAILING . 526 Be	ar Cree	and Number or Rural A K Rd., Fr	oute Number, City or Tow iendsvill	e, M	D 21	531
	20a. METNOD OF DISPOSITION 1 2 Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State camet	PLACE AND DATE Of	ner niecel		1 2 2		- City or Town	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Hu	mberson	Cemete:	ND ADDRESS OF FAC	18,95 Fr	<u>iends</u>	sville	e, MD
	S. Lynn	Neuman	لہ			Homes, P Grantsvil			1506
	23. PART I. Enter the diseases, or com shock, or heart failure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	pilications that caused to the price to the	ch line.	ot enter the me	ode of dying, such	as cerdiac or resp	Iratory a	rrest,	Approximate interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF)	ir					
MEDICAL C	PART II. Other significent conditions of	ontributing to deeth but	t not resulting in	the underlyin	g ceuse given in F	Part I. 24a. WAS AN PERFOR	RMED?	á	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF	DEATH VE		UNCERTAIN			1	☐ YES 2 ☐ NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26	PLACE OF DEATH			ш			
YSIC	XX YES 2 □ NO	OSPITAL: Inpatient 2 ER/Outpat		OTHER: 4 - Nursing Hor	ne 5 X Raaldence 6	☐ Other (Specify)			
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJU	RY W	JURY AT DRK? YES 2 NO	SWD 154			4=
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, atc. (Specify	Al home, ferm, at	reet, lactory, offic	ra (281. LOCATION (Street In City or Town, State)	and Number	-	Nett of HO
COMPLETE	29s. CERTIFIER 1 CERTIFYING PNYSICIAN (Check only one)	N: To the best of my knowled	dge, death occurred			o the cause(a) and mar	ner sa sta	ited.	
TO BE C	29b. AIGNATURE AND TITLE OF CERTIFIER	hill			O.C.M.	BER	29d. DAT		fonth, Day, Year) 15/95
F	MARGORUM D.K	OREW	N (ITEM 27) (Type, 1		T, BALTI	MORE, MAR	YLAN	D 2120	01
3	31. DATE FILED (Morrity, Day, Year) APR 2 1 1995	32. REGISTRAR'S SIGNAT	Rarball						



	1. DECEDENT'S NAME	(First, Middle, Last)						OF DEATH			3. TIME OF DEATH
	EX	RMA	Mearl	140	PK	INS		MON			YEAR 75	3:00 A
	4. SOCIAL SECURITY	NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		8. BIRTH	PLACE (State or Foreign
	UNKNO	OWN	1 🗆 M 2 💢 F	79	YRS.	MONTHS DAYS	HOURS MIN.	June	1 10	15	Wes	" t Virginia
	9a. FACILITY NAME (#	not institution, give	street and number)			96. CITY, TOWN	OR LOCATION OF D		- 1 1 1 7	9c. COUN		
OR	Bon Seco		pital				Baltimo	re			Bal	timore
DIRECTO	RESIDENCE OF	DECEDENT 10b. COUN	TY		10c CI	Y, TOWN OR LOCA	TION					10d. INSIDE CITY
E	MD		Baltimo	ro	100.01		imore					LIMITS?
AL C	10e. STREET AND NUM	IBER	Dartine	716			f. ZIP CODE			10e CITIZ	PEN OF W	1 X YES 2 NO
E.	222 Furr	ow Stre	et					223	- 10			SA
BY FUNE	11. MARITAL STATUS 1 Never Married 3 X Widowed 4	2 Merried	12. WAS DECEDE FORCES?	NT EVER IN U.S. A 1 YES 2 X WAR OR DATES		If yes, st	CENDENT OF HISPA Secify Cuben, Mexic 3 2 NO Speci	NIC ORIGI		or No—	14. RACE	— American Indien, c, White, etc.
ED	15.	DECEDENT'S ED	UCATION			USUAL OCCUPATI		16	b. KIND OF BUS	INESS/IND	USTRY	***************************************
COMPLETED	Elementary/Second		College (1-4 or 5	-	ite. Do NOT u	work done during mose retired.)	ost of working					
MP	8				S	eamstre	SS		Emblem	Manu	fact	ure
00	17. FATHER'S NAME (Fi	rst, Middle, Last)					18. MOTHER'S NA	AME (First,	Middle, Melden	Surneme)		
BE	Harry		Grif	fith			Luc	су			Ta	ylor
5	190. INFORMANT'S NA						end Number or Rural					
_	Esther D				222 F	urrow St	., Balt:	imore	e, MD	21223	3	
	20e. METHOD OF DISP 1 X Burlel 2 Cree		movel from State	20b.PLAC	E AND DATE	OF DISPOSITION (Nother place)	ame of	DA		CATION —		
	4 Donation 5 0				Davi	s Cemete	PTY ND ADDRESS OF F		13 Dav	ris, V	Vest	Virginia
		1/1/2 11	THE			<	0.	~ ,	32 S.	Seco	ia, s	t. 21550
	IMMEDIATE CAUSE	or heart fellure (Finei	. List Dnly one ce	ouse on each li	ne.				rdiec or respi	ratory arro	est,	Approximate interval Between
CATION	shock, iMMEDIATE CAUSE disease or conditio resulting in death) Sequentially list on if any, leading to in cause. Enter UNDE	or heart fellure	a. DUE TO	ouse on each li	tic EOUENCE O	Small	DART ode of dying, aud		rdiec or respi	ratory arro	est,	Approximate interval Between
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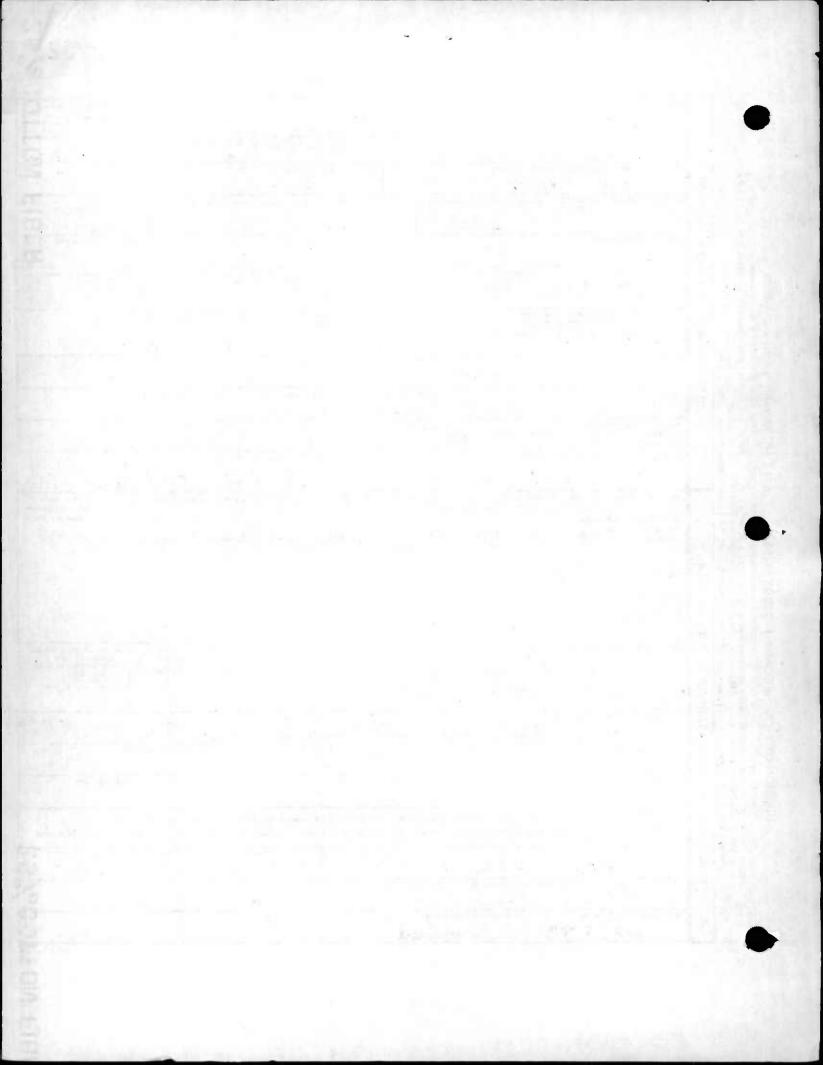
Julia Davidson-Randall

31. DATE FILED (Month, Day, Year)

APR 1 9 1995

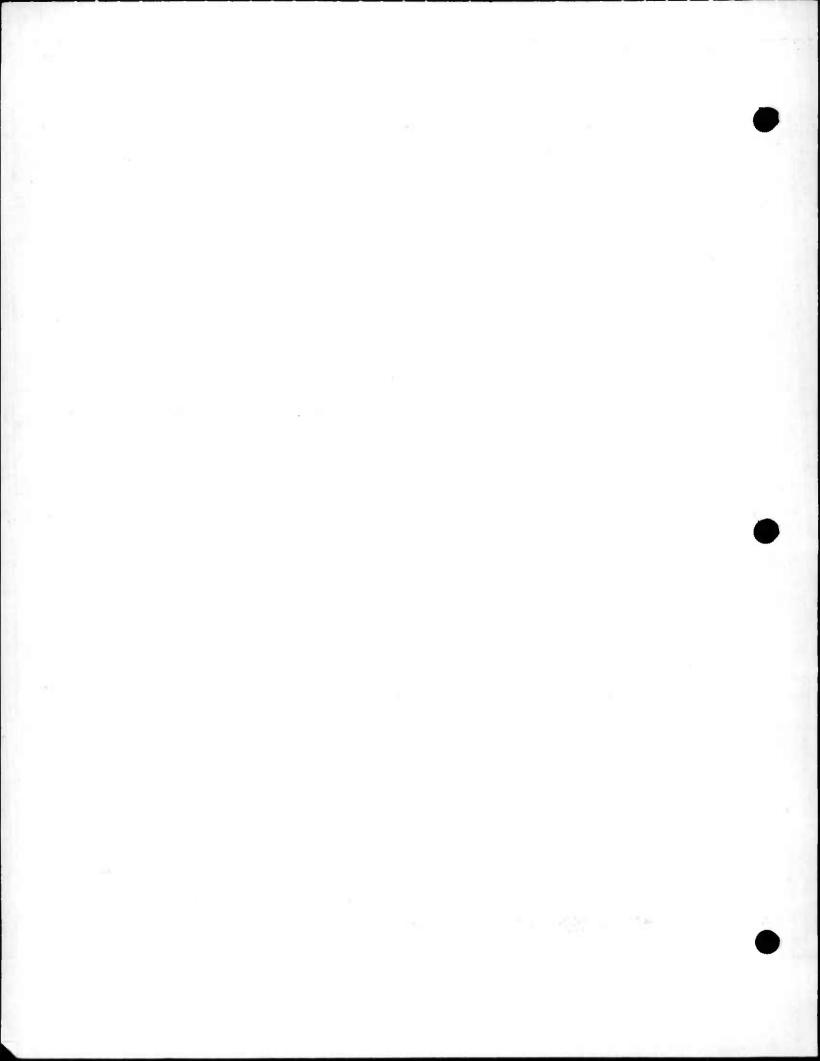
Secons Hospital

DHMH-16 Rev 1/89



FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
DECEDENT'S NAME (First, Middle, Last)		2. DATE O	F DEATH

		REGISTRAR		CERTIF	ICATE O	F DEATH	REG. 1	VO.			
		1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3	TIME OF OEATH	-
		BABY BOY		HAYES			APRIL 1	4, 1995	YEAR	9:30 A. M	м
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			ACE (State or Foreign	_
			1 W 2 F	YRS.	MONTHS DAYS		(Month, Day, Year))	Country)		
pino		9a. FACILITY NAME (If not institution, give a	21		AL CITY TOUG	1 00 100171011 05 0	April 14				_
3 should	a					OR LOCATION OF D		9c. COUNT	Y OF DEAT	тн	
2	DIRECTOR	THE JOHNS HO	PKINS HOSPITA	AL	BAL	TIMORE CI	TY				
S	입	10a. STATE 10b. COUNTY	1	10c. CI3	Y, TOWN OR LOC	ATION			14	d. INSIDE CITY	_
2	<u>ج</u>	Maryland			, , , , , , , , , , , , , , , , , , , ,					LIMITS?	
permit. Pages 1,	1	Maryland 100. STREET AND NUMBER								YES 2 NO	_
	PA	TION. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	N OF WHA	AT COUNTRY?	
1215-0020 r attending physician. use as the burial-transit	FUNERAL										
20 ystci riaH	<u>5</u>	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS D	ECENDENT OF HISPAI specify-Cuban, Mexico	NIC ORIGIN? (Specify	Yea or No- 1	4. RACE -	- American Indian, Vhita, atc.	
0 d d	BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			ES 2 NO Specif			Specify.	White	
215-0020 attending physician se as the burial-trar										wnite	
Se all as	ETED	15. DECEDENT'S EOU (Specify only highest grade	CATION completed)	16e. DECEDENT'S (Give kind of	work done during i	TION most of working	16b. KIND OF	BUSINESS/INDUS	STRY		
ğ 5 15		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)						
Check of	₽										
YLAND 21 by the hospital or be detached for u at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maid	ten Sumame)			Ī
# 2 Z	l w l					Theresa	A. Hayes	3			
MARN retained to 5 should	0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AODRESS (Stree	t and Number or Rural			ode)		-
N reta		Theresa A. Hayes				Avenue, N			,	1 2071/	
ALTIMORE, Jeath. Page 6 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSITION	200	. PLACE AND DATE							_
OR May ector, p	1 1	1 🗆 Burial 2 📉 Cremation 3 🗆 Ram	oval from Stata cen	netery, crematory or o	ther place)	Neme of	OATE 20c.	LOCATION — CH	y or Town,	, State	
M direc		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	1	ne Johns	норкіп	s Hospita	11/4/14/195	Baltim	ore,	Maryland	
min min				_		ANO AODRESS OF FA					
BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physic bd in by the funeral director, page 5 should be detached for use as the burial or removal. medical examiner must be notified at once.		▶ The Johns Hop	kins Hospita	.1	600 N	orth Wolf	e Street,	, Balti	more,	, Maryland	Į
ca att		23. PART I. Enter the diseases, or o	omplications that caused	the death Do	not anter the m	and and duling and	han and a silve	- No. A. Co. Co. Co.			_
in the	1 1	shock, or heart fellure.	List only one cause on a	ach ilna.	not anter the n	loda or dying, suc	n as cardiac or re	spiratory arras	л,	Approximata interval Between	
on, o	1 1	IMMEDIATE CAUSE (Final disease or condition	t has	D		1				Onset and Death	1
within 24 within 24 pletely file cremation, rent, the		resulting in death)	EXIVE	rue Pre	Matu	ily				HOU	
			DUE TO (OR AS A	CONSEQUENCE O	F):	0					
	Z	Securetially list on distance	b								
× m . =	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):						
BOX ate be e hysician prior to	2	Cause. Enter UNDERLYING CAUSE (Disease or Injury	G								1
O. E sertifica fing phy rgiene a	트	that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):						
P. Ce th ce Hyd		resulting in death) LAST	d.								
	1 11									<u> </u>	
	EDICAL	PART II. Other algnificant condition	a contributing to death b	ut not reaulting	in the underlyi	ng causa givan in	Part I. 24a. WAS	AN AUTOPSY ORMEO?		ERE AUTOPSY FINDINGS MILABLE PRIOR TO	
Signed by Health and was any		_ maternal	placeuto abr	wpro				2 NO	CC	MPLETION OF CAUSE	
T S OF T	ME									DEATH?	
A requirements of the state of		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S [] NO [UNCERTAIN			1 "	123 2 2 10	
Pas Pas	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			101				4
SICIAN: The certificate h the State [5	EXAMINER?	HOSPITAL:		OTHER:						-
CLA CLA	ž I	1 VES 2 HO 27. MANNER OF OEATH	1 Impatient 2 - ER/Outp			me 5 Rasidence	1.7. 77				
NG PHYSIC fiter this ce eath with th	РНУ	1 Natural 5 Pending	(Month, Day, Year)	26b. TIM	IURY V	JURY AT YORK?	26d. DESCRIBE HOV	W INJURY OCCUP	RED		1
After the death	A	2 Accident Investigation				YES 2 NO					
TENDIN TENDIN Ther decident		3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	- At home, farm,	street, factory, off	Ice	26f. LOCATION (Stre- City or Town, Sta		Rural Rout	Number,	7
OR ATTEN OR ATTEN DIRECTOR: nours after tem 28 is		4 Homicide determined					ony or lown, one	no/			ı
	1 2	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowl	ladge death occurs	ad at the time, de	to and piece and due	An Abo councies and				٦
보고하는	Ž		R: On the beele of axamination								ı
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	COMPLETED			aivestigatic	, in my opinion,	warn occured at the	ume, data and place,	and due to the c	anse(a) an	or manner as stated.	
ORT ORT	Щ	29b. SIGNATURE AND TITLE OF CERTIFIER		(Neonat	۱ اد	29c. LICENSE NUM	BER	29d. DATE S	IGNED (M	onth, Day, Year)	٦
5 5 8 W	0 8	Trana U.O	are no	Phys	(Nelsis	111176	20	4	4/14/	195	
	일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) Type	Print)	(/ /	0 ()		/ '/		4
		Johns Hopkins	s Hospital	Ba	ltnor	e Mar	Mand	>			
		31. DATE MAYON 0 5 1995	A REGISTRANS SIGN	PURE	V11110		0				4
		MAI 0 0 1995	James an amarion-	nardall		· ·	_				



Pages 1, 2, 3 should permit. the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as notified at once. pe must examiner traumatic event, the medical n and completely filled in by to burlal, cremation, or remo been signed by the attending physician it, of Health and Mental Hygiene prior to other injury, or shows any 23 has OR ATTENDING PHYSICIAN: The After this certificate death with the State marked, or 69 DIRECTOR: A 28 TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 hr IMPORTANT: It is

CERTIFICATION

MEDICAL

PHYSICIAN:

ВY

COMPLETED

BE

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DNATHAN

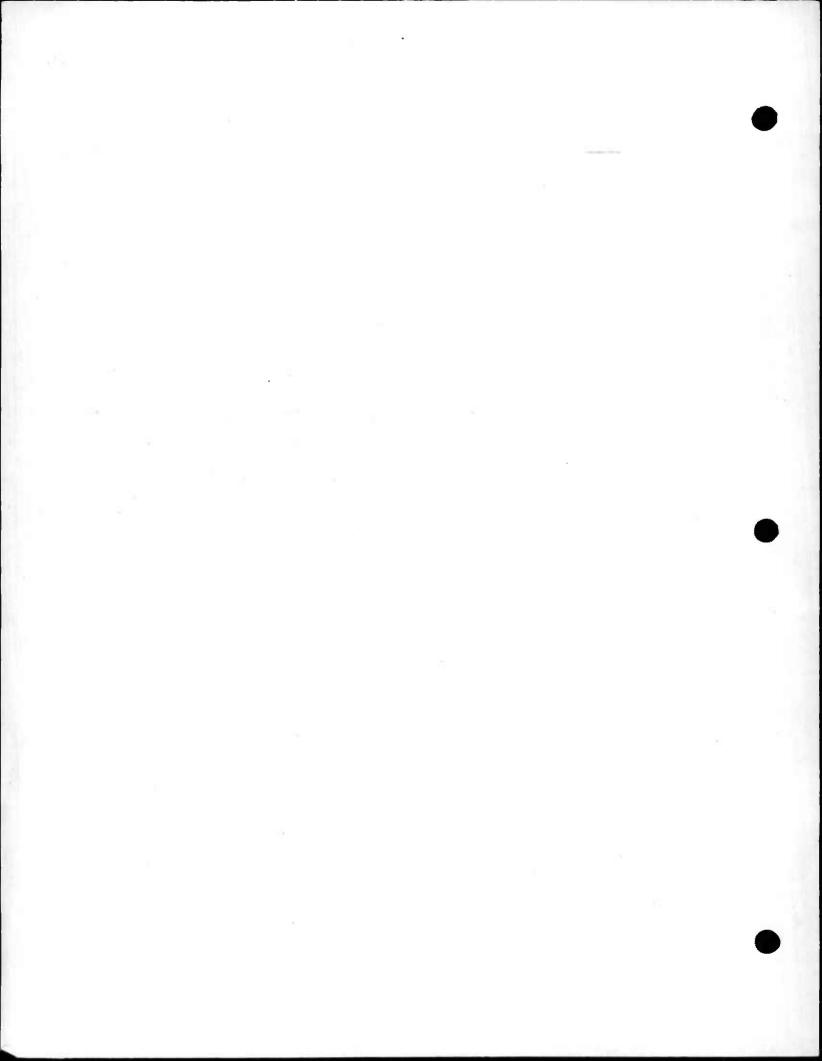
31. DATE FILED (Month, Dex, Year)
APR 18 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 JOHN HREBIK April 14 3:10 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS 6. BIRTHPLACE (State or Foreign HOURS 196-18-0554 0544 1) M 2 F 69 YRS. June 23, 1925 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4004 Lakeview Turn Calvert Dunkirk RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Dunkirk 1 TES 2 X NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4004 Lakeview Turn 20754 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 X NO Specify: В Specify. 3 Wildowed 4 Divorced White ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Aircraft Inspector TWA Airlines 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First Middle Maiden Surname Steve Hrebik BE Helen Petrilla 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine Leason (Sister) 12605 Trumble Drive, Upper Marlboro, MD 20735 20s. METHOO OF DISPOSITION
1 XI Burlet 2 Cremation 3 R
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Peter and Paul Cemetery 4-18 Windber. PA 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 23. PARTY. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) PANCREATIC CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate CRUSA Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 X NO 1 - YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: Inpatient 2 ER/Outpatient 3 DOA 1 TES 2 NO 4 ☐ Nursing Home SXXRasidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE QU 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRINCE FREDERICK,

MD: 120 HOSPITAL

DWELTHAL

32 AEGISTERE'S SIGNATURO



Pages 1, 2, 3 should

funeral director, page 5 should be detached for use as the burial-transit permit.

filled in by the

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90	within 24
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6	å
RECORDS, P.O. BOX 68760	certificate
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REC	requires
_	₩.
Z	The
OF VITAL	G PHYSICIAN:
DIVISION	ATTENDING
	OR.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NES AE GOT PM April 13 7. Date of BIRTH (Month, Day, Year) Apr. 16,1906 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 88 241-30-1584 1 M 2 XF YRS. N. Carolina 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR MONTGOMERY Silver Spring Holy Cross Hospital RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20906 U.S.A. 13207 Dauphine Street 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married ВҮ 1 YES ZY NO Specify Specify: Black 3€ Widowed 4 □ Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. OECEOENT'S EDUCATION 16b, KIND OF BUSINESS/INOUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) 7 t n College (1-4 or 5+) Housewife None 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Golett Hood To Betty Elliott BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Faural Route Number, City or Town, State, Zip Code MD 20906 r) 13207 Dauphine Street, Silver Spring, 2 Marjorine Goggins (Daughter) pe 20s. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State

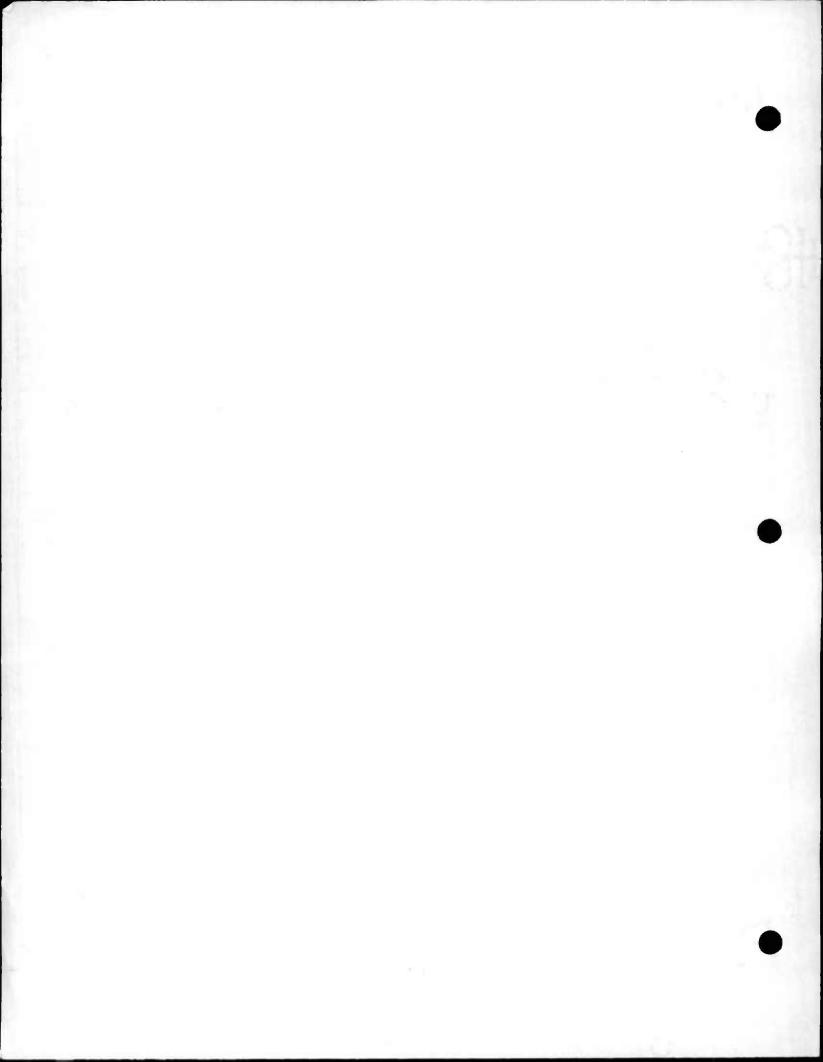
ROCKVILLE, MD 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE 4/22 ParkTawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reepiretory arrest, Approximata shock, or heart failure. List only one cause on each line 6 intervel Batween **IMMEDIATE CAUSE (Finel** Onset and Death cremation, event, the disease or condition been signed by the attending physician and completely of the and Mental Hygiene prior to burial, crematic dure 200 resulting in death) TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART Ji. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? any 1 TYES 2 NO shows : 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO M UNCERTAIN I PHYSICIAN: Dept. certificate has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH with t 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending ВУ 1 YES 2 NO After Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28 is 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 8 Could not be 4 Homicide 29s. CERTIFIER (Check only one) 1 (A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL I = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERT BE 29c. LICENSE NUMBER 34032 2 WHO COMPLETED GAUSE OF DEATH (ITEM 27) (Type, Print) 5 H ER MD 3720 FARRAGU

31. DATE FILED (Month, Day, Year)

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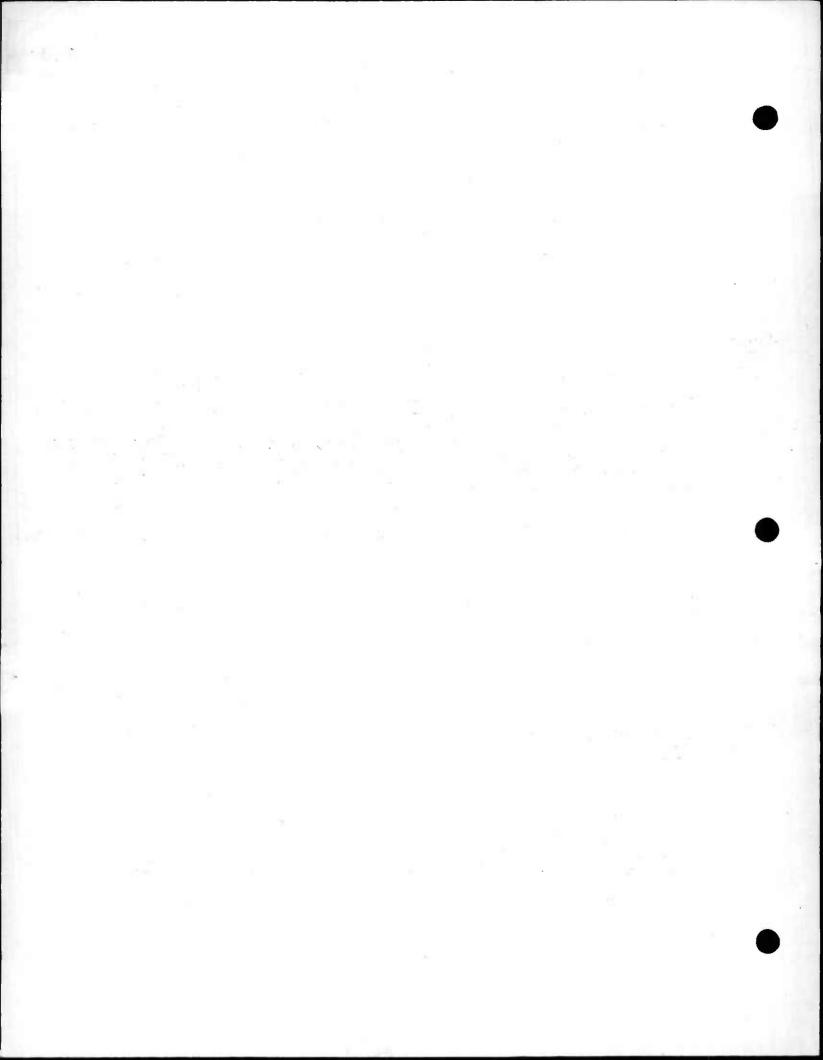
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Davidson Re



DHMH-16 Rev 1/89

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTA	HYGIEN	E			
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		4. SOCIAL SECURITY NUMBER 223-42-5485		(In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH , Day, Year)	1	Country)	ACE (Stete or Fo	reign
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ges 1.	REC	10+. STATE 10b. CO		10c. CI	TY, TOWN OR LOCA	TION				10-	d. INSIDE CITY	,
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5-0020 nding physic	BY F	1 Never Married 2 Noverled 3 Wildowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR D			S 2 NO Speci		lican, atc.)		Consider.	hite, atc.	
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AND he hospita detached i	COMPL	12	2	Homemal	ker		Ow	n Home	9			
Z je E	8	17. FATHER'S NAME (First, Middle, Last				16. MOTHER'S N	AME (First, A	fiddle, Maiden	Surname)			
क विव	BE	Joseph Schuster	`			Magdal						
MA retain 5 sho	5	190. INFORMANT'S NAME (Type/Print) Richard G. Hocev	ar	3310 I	N. Leisu	end Number or Rural re World	Blvd	er, City or Town	state, zip c Silv∈	er Sp	20906 ring,M	d.
IORE, e 6 may be ector, page must be		20e. METHOD OF DISPOSITION 1 Buriel 2\(\text{DA}\) Cremetion 3	Removal from State	b. PLACE AND DATE	OF DISPOSITION (Na	ame of	DATE	20c. LO	CATION — CH	y or Town,	State	
Page 6 m director,		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	etropoli	tan Crem	atory 4/	12/95	Alex	kandri	a, V	irgini	<u>a</u>
BALTIMORE bours after death. Page 6 may bed in by the funeral director, pag or removal. medical examiner must b		· Muriel	N-12a	rher	/ Murie	1 H. Bar Box 503	ber F					
Dours after d in by the or removal		23. PART i. Enter the diseases,	or complications that cause ure. List only one cause on e	d the death. Do	not enter the mo	oda of dying, suc	ch es cerd	lec or respir	ratory arres	t,	Approxim	
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OX 687 e be executed sician and con rior to burial, traumatic en	ON	Sequentielly list conditions,	b	A CONSEQUENCE O	D.		-				 	
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tificate physical phy	畄	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	A CONSEQUENCE O	F):							
THES, P.O. BG that the death certificate ed by the attending physic th and Mental Hygiene pri any injury, or other to	ERTIFI	reaulting in death) LAST	d									
at the death by the atter and Mental y injury, o		PART ii. Other significent cond	Itions contributing to death b	out not resulting	in the underlyin	O cause given in	Part I	24a. WAS AN	umpey	T ash we	RE AUTOPSY FI	1011100
hat the dot of and and in his	MEDICAL	OVALIAN	CANCER		the diadryni	a capas diven in	rait i.	PERFOR	MED?	AM	MILABLE PRIOR	TO
uires the signed Health a							-	1 TES 2	NO	OF	DEATH?	
She she		DID TOBACCO USE CO	NTRIBUTE TO CAUSE O	DE DEATH Y	ES [] NO [UNCERTAI	NI IXI			1 [YES 2 N	10
AL he law he law e Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICA		26. PLACE OF DEA			14 24					
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

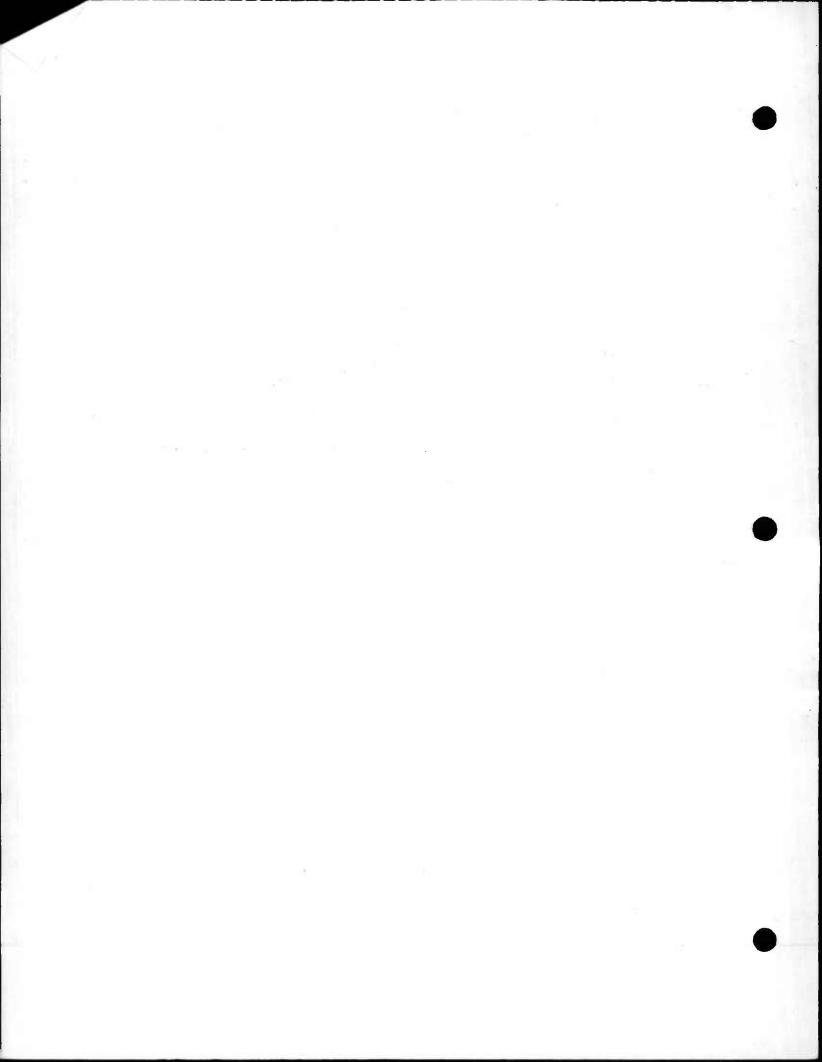
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 -	FOR STATE REGISTI	RAR
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F	4. S	OCIAL SEC	URIT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - REGISTRAR		CERTIFI	CATE OF	DEATH		REG. NO	-				
1. DECEDENT'S NAME (First, Middle, Las	it)					OF DEATH		3	. TIME OF DEATN		
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4. SOCIAL SECURITY NUMBER 551-80-5957	5. SEX 6	AGE (In yrs. lest birthday) 44 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7 DATE	OC DIDTH	- 1		ACE NEW YORK KSON HGTS		
9a. FACILITY NAME (If not institution, give				OR LOCATION OF DI	EATN	TIDLK!	9c. COUNT	Y OF DEA	TH		
NATIONAL NAVAL RESIDENCE OF DECEDENT 10a. STATE VIRGINIA FAI				IESDA			MOI	NTGO]			
	RFAX		AIRFAX	TION	2				Dd. INSIDE CITY LIMITS?		
10e. STREET AND NUMBER 5408 CHATSWOF 11. MARITAL STATUS 1	TH COURT		10	22032					STATES		
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 117 IF YES, GIVE WAR DFC 18 198		If yes, sp	ENDENT OF HISPAI ecify Cuban, Maxics 2 NO Specif	an, Puarlo F	? (Specify Yas lican, etc.)			- American Indian, Whita, atc.		
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) 17. FATNER'S NAME (First, Middle, Last)	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18a. DECEDENT'S USUAL OCC (Give kind of work done du iffe. Do NOT use retired.)						SINESS/INDUS	TRY	FORCE		
17. FATNER'S NAME (First, Middle, Linst)	4	OFFICER				Was and a					
JOHN HNAT				ADALIN	E ADA	MS					
1981. INFORMANT S NAME (Type/Print)				nd Number or Rural					2222		
200. METNOD OF DISPOSITION		20b. PLACE AND DATE O		TH COURT	, FAI		VIRGI	_			
1 Burial 2 ACremation 3 Re 4 Donation 5 Other (Specify)	movel from State	cemetery, cremetory or oth	her place)								
21. SGNATURE OF FUNERAL SERVICE	LICENSEE	MELIKOPOLI LA	28 HAME A	Y FUNERA	CILITYON	E TAY	ALEAAL	IDKI	A. VA.		
Lucy of	elael	Ray	4510	VILSON B	LVD.	ARL. V	A. 222	03			
23. PART i. Enter the disesses, o shock, or heart failure	r complications that ca	used the death. Do no	ot anter the mo	da of dying, auc	h ss card	iac or respi	ratory arres	t,	Approximsta interval Between		
iMMEDIATE CAUSE (Finsi disease or condition resulting in dasth) s. HEPATIC-RENAL FAILURE											
s. HEPATIC—RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):											
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If sny, isading to immediata cause. Enter UNDERLYING			,								
Sequantislly list conditions, if sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST											
	ons contributing to dsa	th but not resulting in	n the underlying	g csuss given in	Part i.	24a. WAS AN			ERE AUTOPSY FINDINGS		
PART II. Other significant condition					_	PERFOR		CC	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?		
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH	TRIBLITE TO CALIC	E OF DEATH VE	C T NO T	1				1	YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSI	26. PLACE OF DEATH		UNCERIAII	иПТ						
EXAMINER? 1 TYES 2 TO NO	HOSPITAL:		OTHER:	e 5 🗆 Realdence	6 Other	(Specify)					
27. MANNER OF DEATH	28a. DATE OF INJU	IRV 285 TIME	OF 28c, INJ	URY AT			JURY OCCUP	ED			
1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	RK? /ES 2 NO			_				
2 Accident Investigation 3 Suicide 8 Could not b 4 Homicide detarmined	3 Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify)										
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force.	Cre	imo		D-43700					95		
30. NAME AND ADDRESS OF PERSON W	/HO COMPLETED CAUSE OF		Print)	NATIONAL		AL MEI					
T.S.KNEE, LCDR				BETHESDA							
31. DATE FILED (Month, Day, Year) APR 1 7 100	32. REGISTRAR'S	SIGNATURE									





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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho	JERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, o
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95 13758 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH April 19, 1995 Velma Arlene Heine 7:55 p 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 - M 2 F 343.10.2532 78 Jan.16,1917 **Illinois** Se. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Nursing Home Rockville Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery 1X YES 2 NO Derwood FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7204 Blanchard Drive 20855 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY Specify: White ¥XX Widowed 4 ☐ Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary State Department Once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) Ħ Ross J. Scaggs Inez Ethel Zehner BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Carol Lee Martin 35th Avenue Kenosha, WI 53144 Pe 20e. METHOD OF DISPOSITION
1 ☐ Burlet 2 K Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Mt. Comfort Crematory 4 ☐ Donation 8 ☐ Other (Specify) 4-24.95 Alexandria, Va. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons tal 4 5130 Wisconsin Ave. N.W. Washington D.C. medical 23. PART il Enter the diseeses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feilure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death** event, the disease or condition CEREBRO VASCULAR ACCIDENT recuiting in death) 4 WEEKS DUE TO (OR AS A CONSEQUENCE OF): traumatic <u>0</u> Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ATRIAL FIBRILLATION any 1 TYES 2 PHO shows : 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IN UNCERTAIN IN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: OTH/BR:
4 D/Nursing Home 5 - Residence 6 - Other (Specify) 1 YES 2 NO 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. MANNER OF DEATH 28s. DATE OF INJURY marked, 28c, INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED (Month, Day, Year) 1 Natural 5 Pending BY 1 YES 2 NO Investigation 2 Accident DIRECTOR: At hours after de item 28 is r 3 Sulcide 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL DR AT
TO THE FUNERAL DIRECT
DE filed within 72 hours a
IMPORTANT: If item 2 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the lime, data and place, and due to the ceuse(s) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the lime, date end piece, end due to the cause(e) end manner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D 36552

50 W Edmonston Dr. #401 Rockville, Md. 20852

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Pankaj Talwar, M.D.

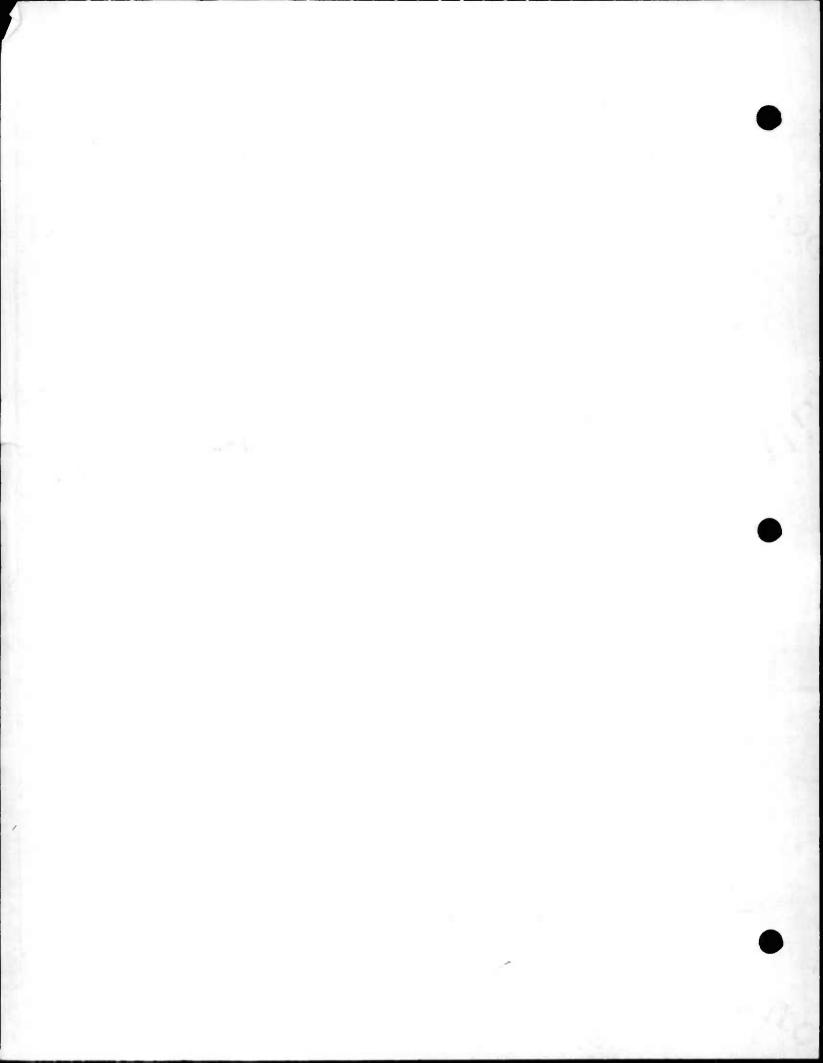
31. DATE FILEO (Month, Day, Year)

APR 21 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIN ATURE

APRIL 19, 1995



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n 24 hours after death. Page 6 may be retained by the hospital or attending physician.	nould be detached for use as the burial-transit p
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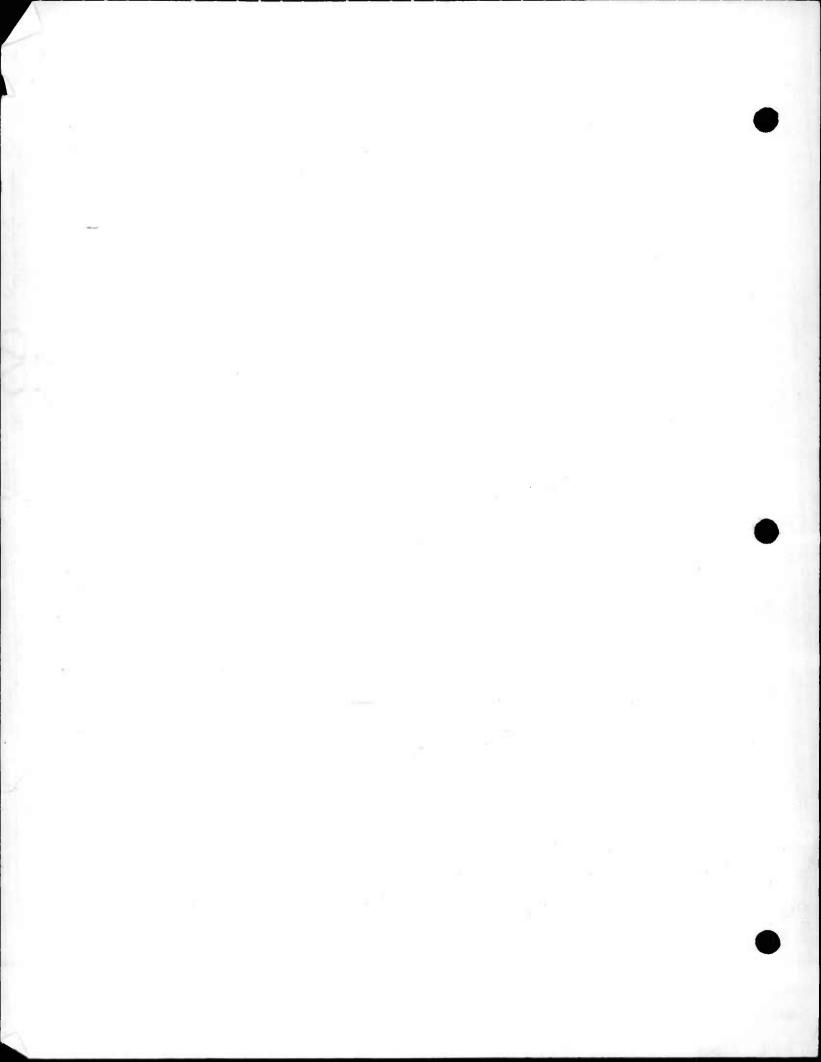
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Mark Harner April 995 0250 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birtnday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 -M 2 -F 21 448-90-0943 1973 JULY 11, OKLAHOMA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel General Hospital Annapolis Anne Arundel 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY OK. OKLAHOMA MIDWEST 1 X YES 2 | NO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 817 FAIRLANE DR. 73110 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11 MARITAL STATUS 14. RACE — American Indian, Black, White, stc. 1X Never Married 2 Married B₹ 1 TYES 2 THO Specify: 3 Widowed 4 Divorced WHITE ACTIVE DUTY COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 U.S. NAVY **DEFENSE** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at MARK THOMAS HARPER B MERINDA MADDEN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Bural Route Number, City or Town, State, Zip Code) 9 MARK HARPER SAME AS ITEM #10 2 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Sista must Buriel 2 Cremetion 3 Removal from State RESTHAVEN MEM. GARDENS Donation 5 Other (Specify) 4/21 SEMINOLE, OK. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 20737 M00091 W. W. CHAMBERS CO., RIVERDALE, MD. medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximste ehock, or heart feilure. List only one cause on each line interval Between IMMEDIATE CAUSE (Finsi Onset and Death the disease or condition resulting in death) MULTIPLE INJURIES event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? shows any 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) ltem. HOSPITAL OR ATTENDING PHYSICIAN: The the State HOSPITAL: OTHER: XXYES 2 NO 1 Inpetient 2 ER/Oulpatient 3X DOA 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 4-15-95 28b. TIME OF INJURY 2 A M 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 Natural DRIVER OF AUTO THAT OVERTURNED 1 TES 2 NO BY After t 2 Accident 3 Sulcida 28e. PLACE OF INJURY — At home, larm, streel, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be DIRECTOR: / 4 Homicide detarmined ROAD EASTPORT, ANNAPOLIS, MD. COMPLET hours 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL within 72 h TANT: If I TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: If 2X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 10 C.M.E. APRIL 15/95 9 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Year)

	An	mended # 1, 41 FOR 1- STATE	7b, 4/3 21/95, STATE OF M	2 7/95 J W/, MARYLAND /	M. DEPAR	RT	50 m	non ner IEALTH	tg.	Cou	rry n+y HYGIEN	- 95 E	pul	3360
		1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 235-14-1992	Love 5. SEX	7	Te	tra		DEAT OU	K 24 HRS.	2. DATE O MONTH APT1.	F DEATH DA	1995	YEAR	3. TIME OF DEATH 2:10 P LACE (State or Foreign
, 2, 3 should	стоя	9a. FACILITY NAME (If not institution, give s Holy Cross Hospi	treet end number)	77	THS.			Spr	ON OF DEA		2,19	9c. COUN	West TY OF DEA ntgom	
020 physician. burial-transit permit. Pages 1, 2, 3 should	DIRE	10e. STATE 10b. COUNT	ard			y, town		ION	E			10a CITIZ		Od. INSIDE CITY LIMITS? YES 2 1 NO AT COUNTRY?
215-0020 attending physician. se as the burial-transit p	BY FUNERAL	3661 Jennings Cl 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DECI	2179 ENGENT OF	7 OF HISPANIC n, Mexican,	ORIGIN? Puerto Ric	(Specify Yee cen, etc.)	U	SA 14. RACE - Bleck,	- American Indian, White, atc.
	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(G life.	CEDENT'S tve kind of w Do NOT us	vork done e retired.)	during mos	DN st of working	og		wn Ho			WILLE
MARYLAND 2- retained by the hospital of 5 should be detached for notified at once.	O BE CO	17. FATHER'S NAME (First, Middle, Last) James William Ju 190. INFORMANT'S NAME (Type/Print)						Ma:	ry Ma	argar	et Go	rby n, State, Zip		21797
e age		Albert E. H. Ho 20a. METHOD OF DISPOSITION 1 [2] Burlel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIK	oval from State	20b. PLACE/ cernetery, cre Natio	ANDDATEC	per place, 1emo	sition (Nai rial	maot Park	c 4/	24/9.	odbin 20c. LOC 5 Fal:	CATION — C	aty or Town	
# > E 3		23. PART I. Enter the disasses, or of	ind	t caused the da	ath. Do n	F 5	ranc 00 U	is J. nive	rsity	lins Blv	Fune	Sil.S	bor.M	Inc. D 20901
within 24 within 24 pletely fille cremation, the		IMMEDIATE CAUSE (Final	a. Heyaf	aa on aach Ilna		ريان	re				•			Interval Between Onset and Dead
P.O. BOX 68: th certificate be execute ending physician and or I Hygiene prior to buria or other traumatic	ERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		(OR AS A CONSEC								5		Stanly
ORD s that the ned by the ith and M any inju	MEDICAL CI	PART II. Other algnificant condition	a contributing to	death but not n	eaulting is	n tha u	ndarlying	cause g	ivan in Pa		4a. WAS AN PERFORI		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
TAL. The law the has ate Dept	PHYSICIAN: M	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 — YES 2 — NO	HOSPITAL:	26. PLAC	E OF DEAT	N (Check	only one)		ERTAIN			-	1	YES 2 NO
OF PHYSIC this cer with th	D BY PHY	27. MANNER OF OEATH 1	28s. DATE OF (Month, Di	INJURY ny, Year) F INJURY — At hor	28b. TIME INJU	OF URY M	28c. INJU WOF 1 Y	JRY AT RK? ES 2	NO	tad. DEŞCI	Specify) RIBE NOW IN			te Number
DI TAL DR AL DIRI 72 hour	COMPLETE	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of	my knowledge, der	nth occurre	d at the t	lime, date o	end place,	end due io	City or	Town, State) (e) end mens	ner ee atate	d.	
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I	TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER							NSE NUMBI					Ionth, Day, Year)
		La Var Kreen Moon 9995 Ju	My Mh	Rudoth	SIN	109	(cal	Do	auls	11-	Sdr	40 Sp	ming.	Md 20902

ITEMS: 10d, & 23 PART II, PER DR. FILM G-723 5/10/95 t.t



DIVISION OF VITAL RECORDS, P.O. BOX 13146,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Aus after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF N				OF HEALTH AND	MENTA	L HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Last)			· · ·	0. 02		OF DEATH			TIME OF DEATH	
	HELEN Louise HAUGH					APR	H DAN		EAR	6:06 A ^M	
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last		IF UNDER	YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH			BIRTHPL/	ACE (State or Foreign	
	216-46-8199 1□ № 2 🗓 🖡	88	YRS.				24=1907		Mary	land	
~	9a. FACILITY NAME (if not institution, give atreet and number)				TOWN OR LOCATION OF D	EATH		9c. COUNTY			
Ď.	Williamsport Nursing Home			MITI	iamsport			Washi	ngto	n	
E	10e. STATE 10b. COUNTY		10c. CITY	, TOWN O	R LOCATION		- 0		10-	d. INSIDE CITY LIMITS?	
0	Maryland Washington		Hac	jerst						YES 2 NO	
BY FUNERAL DIRECTOR	100. STREET AND NUMBER 1411 Potomac Avenue				101. ZIP CODE 21742				T COUNTRY?		
NE.	11. MARITAL STATUS 12. WAS DECEDEN	T EVER IN U.S. AR	MED	13 V	WAS DECENDENT OF HISPA	NIC OBIGI	N? (Specify Vee		S.A.	American Indian,	
F	1 Never Merried 2 Merried FORCES? 1	YES 2 W	10	- 10	yes, specify Cuben, Mexico	an, Puerto		J	Black, W Specify:	hite, etc.	
	3 Widowed 4 Divorced		,						,	White	
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Gi	Ve kind of w	ork done d	CUPATION luring most of working	186	b. KIND OF BUS	INESS/INDUS	TRY		
PE	Elementary/Secondery (0-12) College (1-4 or 5 + 12 years)	memak				Persona	al Res	iden	nce	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA						
BE C	David H. Flory Jr.				Ruth			John	son		
TO B	19a. INFORMANT'S NAME (Type/Print)				(Street end Number or Rural						
-	Joann E. Carroll Haugh				t Avenue Ha						
	20e. METHOD OF DISPOSITION 1 Straight 2 Cremation 3 Removal from State	St other ple	OF DISPOS	ITION (Nai Cen	ne of cemetery, crematory or			ation - cit		Maryland	
	21. BIGHATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							2 20			
	bl land of Q.				ouglas A. F						
	23. PART I. Enter the diseases, or complications that	t caused the da	ath. Do n		31 Eastern					21742 Approximata	
	shock, or heart fellure. List only one cause off each line.										
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):									Onset and Dasth	
	DUE TO	(OR AS A CONSE	DIAL.): INFA	RCTION					10 MINS.	
N	Sequentially list conditions,										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING										
임	CAUSE (Disesse or Injury that initiated events	(OR AS A CONSEC	DUENCE OF):							
F	resulting in dasth) LAST										
LC	PART II. Other significant conditions contributing to	desth but not r	esulting i	n tha un	darlying cause given in	Part I.	24a. WAS AN			ERE AUTOPSY FINDINGS	
ICAL							PERFOR		CC	MILABLE PRIOR TO DMPLETION DF CAUSE	
밁								A.	1	F DEATH?	
ž											
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:			OTHER	26. PLACE OF DEATH (C	heck only o	one)				
IXSI		ER/Outpatient 3		4 📉 Nurs	olng Home 5 - Residence	1					
	1 Natural 5 Pending (Month, D	ony, Year)	28b. TIMI INJ	URY M	26c. INJURY AT WORK? 1 YES 2 NO	28d. DE	SCRIBE HOW II	NJURY OCCUI	RED		
BY	2 Accident investigation 3 Suicide 6 Could not be 28e. PLACE C	F INJURY — A1 ho	me, farm, s	treet, fact			CATION (Street a	nd Number or	Rurel Roul	le Number,	
COMPLETED	4 Homicide determined	atc. (Specify)				Clh	y or Town, State)				
F	29e. CERTIFIER (Check only (Ch	my knowledge, de	ath occurre	d at the ti	me, date end place, end du	n to the co	ouse(a) and men	ner ee stated.			
No.	one) 2 MEDICAL EXAMINER: On the basic of e	xamination end/or	Investigatio	n, In my o	pinion, death occured at th	e time, del	la end pieca, an	d due to the	causo(e) a	nd manner as stated.	
BE C	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NU	JMBER		29d. DATE S	IGNED (M	lonth, Day, Yeer)	
TO B					D 337	00		AP	RIL	25, 1995	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU										
	TED E. HOWE, M.D., 154 N 31. DATE FILED (Month, Day, Year) 32. REALSTR.	UKIH AK'.	LIZAN	STR	EET, WILLIA	MSPO	RT. MD	2179	5		
	APR 2 6 1995 Jalia	Bowlerak	melell								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	: FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burdal-transit permit. Pag	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE H	TO THE F.	be filed w	IMPORT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Malcolm Frederick Hose 0240 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Morth, Day, Year)
Dec. 19, 1912 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 220-05-6789A 1 1 2 1 2 82 YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital 7 Wash. Hagerstown RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 YES 25 NO 10a. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 878 Frederick Street 21740 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 1 YES 2 X NO Specify: Specify 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 sand blasting machinist 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Nelvie Hose BE Lillie Carbaugh 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jane Dorsey 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 K Burial 2 Cremation 3 Removal from State Broadfording Cemetery 4 Donation 5 Other (Specify) 4-22-95 Hagerstown, Marylande 21. SIGNATURE OF FUNERAL BEHVICE LICENSEE MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haart fallure. List only one cause on each line interval Between IMMEDIATE CAUSE (Finel Onset and Daath disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Rep una Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING alais hludio CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? China Offation Untracas Disson 1 YES 2- NO OF DEATH? Gunnina 1 YES 2 NO DID TÓBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖸 NO 🗌 UNCERTAIN 🖯 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO tient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 8- Natural BY 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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5555	rs after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND /	DEPAR	TMEN ICAT	T OF H	HEALTH DEAT	AND I	MENT	AL HYGIEN				
	1. DECEDENT'S NAME (First	, Middle, Leat)	-							2. DAT	E OF DEATH			3. TIME OF DEAT	H
	Margaret	Lee		HOWARD						MON Q4		AY	YEAR	0830	м
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UND	ER 1 YEAR	IF UNDER	24 HRS.	- '	E OF BIRTH	1-	A BIRTI	IPLACE (State or Fo	velan.
	214-09-193	6	1 M 2 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	S O D	t. 18, 19	112	Counti	(y)	· orgii
	9a. FACILITY NAME (If not in	nstitution, give s	street and number)	0.1	_	Oh CIT	Y TOWAL	OR LOCATE	ON OF B		L.10,1		INEW	York	
œ	2750 Virgi									EATH					
16	RESIDENCE OF DEC		enue			V	1111	Lamsp	ort			- V	lashi	ngton	
DIRECTOR	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY	
1 2	Maryland	Wash	ington		W	:11:	Lamsp	ort						LIMITS?	
1	10e. STREET AND NUMBER				1		-	. ZIP CODI	F			100 017	TIZEN OF Y	WHAT COUNTRY?	NO
1 2	2750 Virgi	nia Av	enue						- 1795					mar cookinii	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. As	PMED	12	WAS DEC				IN? (Specify Ye		SA		
	1 Never Married 2	Married	FORCES? 1	YES 2-	NO	"	If yes, sp	ecity Cuba	n, Maxica	n, Puarto	Rican, etc.)	or No-	Black	E — American India k, Whita, etc.	in,
B	3 🙀 Widowed 4 🗌 Divo	orced	IF YES, GIVE Y	MH OH DATES			1 YES	2 🔀 NO	Specify	y :			Speci	‰ White	
03	15. DEC	EDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL (OCCUPATION	ON		10	b. KIND OF BU	SIMESS/IN		WILLE	
E	Elamentary/Secondary (0	y highest grade	College (1-4 or 5	W ₀	live kind of a Do NOT us	work done se retired.	during mo	at of working	ng .						
COMPLET	12	,	4	"	SEC	reta	rv				Retail	noi	nta		
õ	17. FATHER'S NAME (First, M	liddle, Last)			- 550	1000		18. MOTA	HER'S NA		Middle, Maiden		ILS		
	Otto Perry	Bohman	n								l Pyles	,			
BE	19a, INFORMANT'S NAME (7			10	h MAII INC	ADDRES	26 (Steat o	and Mumbas			9				
일	Margaret B.		rd	nr	e-ar	rano	CTLOST 8	t a	2750	Vii	nber, City or Tow rginia	Aven	ue		
3	20a. METHOD OF DISPOSIT				C ai	Lane	CINCII	Lo	Will	iams	sport.	Md.	<u> 2179</u>		
	1 🖾 Burial 2 🗆 Crematio 4 🗆 Donation 5 🗆 Other	n 3 🗆 Ram	oval from Stata	cemetery, cre	matory or o	ther place	J		, ,	1		CATION —			
	21. SIGNATURE OF FUNERA		FNSEE	Rose	HIII			Y ADDRES) Hag	erst	own,	Marylan	ıd
		>-	m	27.5	^			CH F			OME				
	00	OU	0010	MNI	nes	/						eret	Otm	Md. 217	40
	23. PART i. Enter tha di	iseases, Dr C	omplications tha	t caused the de	ath. Do r	not ente	r tha mo	de Df dyl	ng, suc	h as ca	rdiec pr resp	iratory ar	rest.	Approxima	
	ahock, or he IMMEDIATE CAUSE (Fin	eart fallure.	List only one ceu	se on each iine							•		,	interval Be Onset and	tween
	diseese or condition		A. Com	· Alexander										Oriset and	- /
	resulting in death)		DUE TO	(OR AS A CONSE	OUENCE O	P. 0/07	~_	121	THA	CT	CUN			SUDDE	510
-		_	ANTERIE											100	
CERTIFICATION	Sequentially list conditi		DUE TO	(OR AS A CONSE	OUENCE OF	<u>けて</u> D:	MK	DI	JEA	7				YEAR	עיי
¥	if any, leading to immed cause. Entar UNDERLY!	NG				•								j	
	CAUSE (Diseese or Inju that initieted events	ry 5	DUE TO	(OR AS A CONSE	QUENCE OF	F):								- i	
E	resulting in death) LAS	т												į	
씽			d												
뒿	PART II. Other aignifica	nt condition	a contributing to	deeth but not r	esulting i	n the u	nderlying	cause g	iven in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FIR	
MEDICAL	NOA	18									PERFOR			AVAILABLE PRIOR 1 COMPLETION DF CA	
E I										_	1 123 2	NO		OF DEATH?	
2	DID TOBACCO U	SE CONTI	PIRLITE TO CA	LISE OF DEA	TH VE	с П	NO D	LINC	ERTAIN					1 NES 2 N	°
PHYSICIAN:	25. WAS CASE REFERRED TO		NIDOTE TO CA		E OF DEAT			DINC	EKIAII	1 2					
100	EXAMINER?		HOSPITAL:	The second second		OTHE	N.								
≥	27. MANNER OF DEATH		1 Inpetient 2 I		26b. TIM	_			sidenca		er (Specify)				
		Pending	(Month, Di	lly, Year)		URY		RK?	.	28d. DE	SCRIBE HOW I	NJURY OC	CURED		
B	2 Accident Investigation M 1 YES 2 NO 3 Suicide 6 Could not be 26s. PLACE OF INJURY — At home, farm, street, factory, office 26s. LOCATION (Street and Number or Bural Route Number)														
0		Could not be detarmined	building,	FINJURY — At ho atc. (Specify)	me, farm, a	itreef, fac	tory, office				CATION (Street I or Town, State)		or Rural R	oute Number,	
=															
COMPLET			CIAN: To the best of												
8			R: On the basis of a											and manner as str	Med.
m O	191 SIGNATURE AND TITLE							29c. LICE						(Month, Day, Year)	
	se me	1	NO					-	104			DAI DAI	24_	(U_C -	
일	30 NAME AND ADDRESS OF	PERSON WILL	COMPLETED CALL	E OF DEATH "TO	4 am /3	D-(-+)		VO	107				- 7-1	7-75	

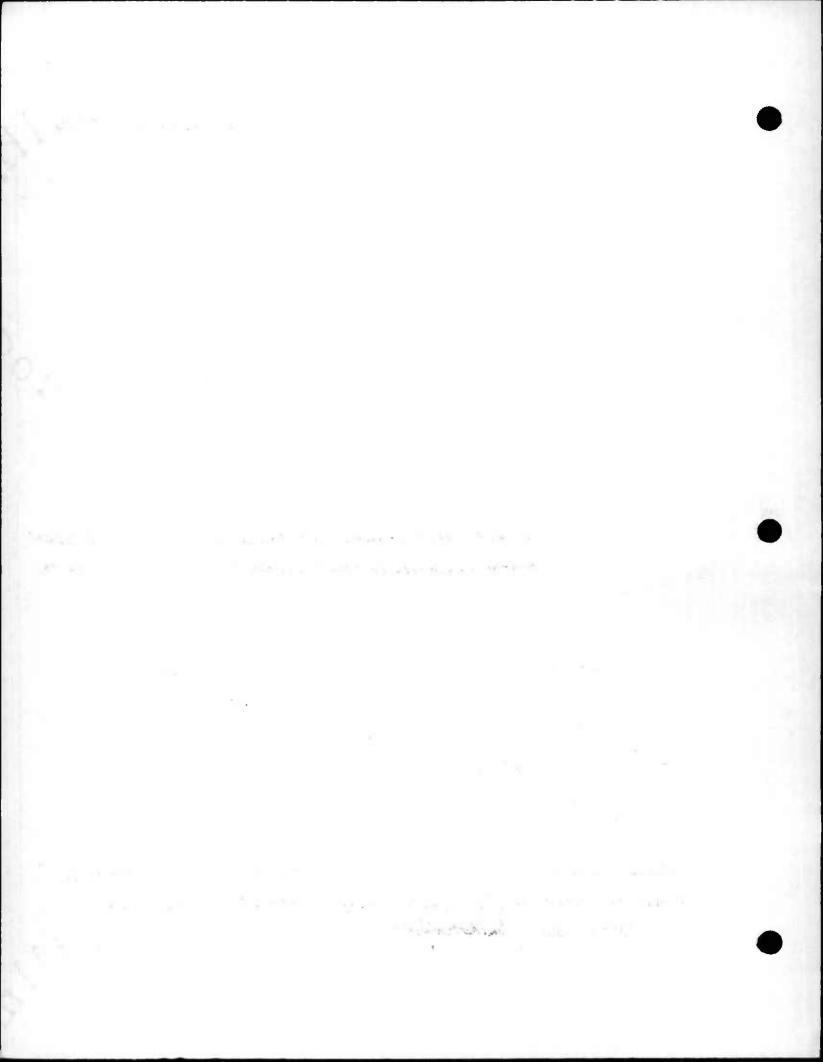
PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KESTUDOD DRY

45

13 pmny M. Cotter, 31. DATE FILED (Month, Dey, Year) APR 1 7 1995

HAGENSTOWN, MD 2174



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Hypatia Virginia HOTT Horil 09/16 4. SOCIAL SECURITY HUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF LINDER 24 HRS 7 DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Sep. 2, 1921 216-14-5687 1 M 2 X 73 VRS Maryland Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUHTY OF DEATH DIRECTOR Washington County Hospital Wash Hagerstown inatom RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Williamsport 1 YES 2 1 HO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 15215 Saber Rd. 21795 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECEMBENT OF HISPAHIC ORIGIN? (Specify Yes or Ho-**BALTIMORE, MARYLAND 21215-0020** 14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married Il ves, specify Cuban, Mexican, Puerto Rican, etc.) BY 1 YES 2 NO Specify. 3 K Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing Manufacture 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surname) notified at James Lesley Keeney Minnie Belle Wetzel BE 19a. IHFORMANT'S HAME (Type/Print) 19b. MAILIHO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donald L.Hott 1359 State Line Rd. Waynesboro, PA 17268 De la 20e. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE Green Tawn Memorial Park April 28, 1995 Williamsport, MD 21795 examiner 22. HAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 the or removal. event, the medical been signed by the attending physician and completely filled in by at of Health and Mental Hygiene prior to burial, cremation, or remo 23. PART WEnter the diseases, or complications that ceused the death. On not enter the mode of dying, such ea cerdiec or respiratory arrest, Approximata shock, or heart failure. List pnly one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in deeth) ACUTE MYOCARDIAL day DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): DRONARY traumatic ARTER CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF If any, leading to immediate cause, Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AH AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE any HYPERTENSION MELLITUS 1 YES 2 NO OF DEATH? DEMENTIA INFARCT 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has by hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t HOSPITAL: 1 YES 2 HO OTHER: Inpatient 2 - ER/Oulpatient 3 - DOA 4 - Hursing Home 5 - Residence 6 - Other (Specify) marked, or 27. MANHER OF DEATH 28a. DATE OF IHJURY (Month, Day, Year) 28b. TIME OF 28c. IHJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Hetural 5 Pending м BY 1 YES 2 HO 2 Accident 28e. PLACE OF IHJURY — At home, lerm, street, factory, office building, stc. (Specify) 3 Suicide .00 28I. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 29e. CERTIFIER (Check only one)

2 MEDICAL SYMMED: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. TO THE HOSPITAL O
TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMIHER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICEHSE HUMBER BE JO 138892 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRAD HOWELL RA 1799 HAGERSTONN MA

31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30. NAME AND ADDRESS OF PER ABDUL W

ABDUL W.
31. DATE FILED (Month, Day, Your)

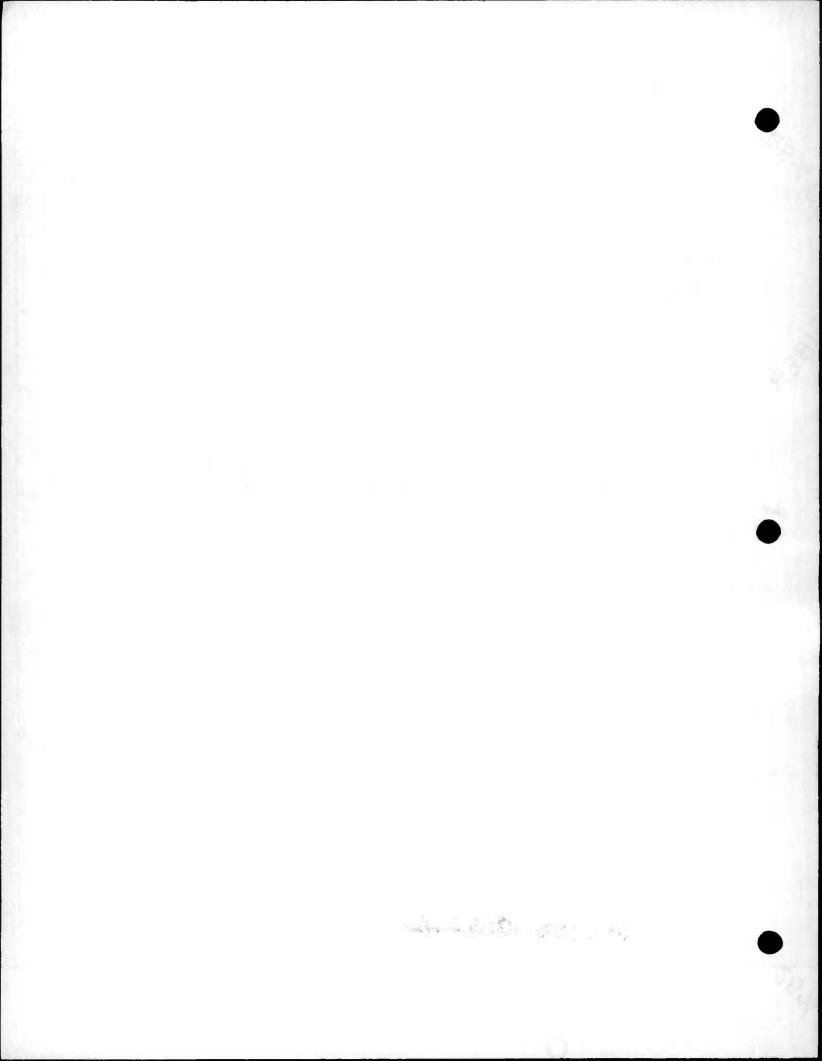
APR 24

									9	5	3765
	1 - STATE REGISTRAR	STATE OF MARY			OF HEALTI		MENTAL	HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	Elmer Guy		ERSHO			2. DATE (OF DEATH	"1 19	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		RE (In yrs. last birthday)	IF UNDER		ER 24 HRS.	7. DATE C	OF BIRTH Day, Year)		8. BIRTHPL	ACE (State or Foreign
	235-34-6082		73 YRS.		DAYS HOURS		Oct.	20, 19	921		Virginia
l m	9a. FACILITY NAME (If not institution, give			9b. CITY,	TOWN OR LOCA	TION OF D	EATH		9c. COUN	NTY OF DEAT	TH .
DIRECTOR	Washington Count	y Hospital			Hagerst	own			Wa	shing	ton
, EC	10a. STATE 10b. COUNT	ſΥ	10c. Cf	TY, TOWN O	R LOCATION					10	id. INSIDE CITY
	Halyland	ontgomery			Rockvil	1e				1	LIMITS?
AL	100. STREET AND NUMBER	A			101. ZIP CO		252		10g. CITI	ZEN OF WHA	T COUNTRY?
FUNERAL	13200 Magellan						853			.A.	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER	S 2 NO	13. V	MAS DECENDENT f yes, specify Cut	OF HISPAI	NIC ORIGIN	(Specify Yes	or No-	14. RACE — Black, W	American Indian, /hite, etc.
B	3 Widowed 4 Divorced	W.W. I	DATES		YES 2 NO				- 1	Specify:	hite
8	15. DECEDENT'S EDL	JCATION	16a. DECEDENT'S	S USUAL OC	CCUPATION		18b.	KIND OF BUS	INESS/IND		Hite
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done d ise retired.)	during most of worl	king					
MP	12	6	Elemen	tary	School	Teac	her	Pub1:	ic Sc	hools	
8	17. FATHER'S NAME (First, Middle, Last)				18. MO	THER'S NA	AME (First, M	liddle, Maiden	Surname)		
BE	Clyde Hendershot						ca Cr				
2	19a. INFORMANT'S NAME (Type/Print) Nancy Beall		196. MAILING 2408	a ADDRESS Doubs	Ct., A	er or Aural	Route Number	M.d.	n. State, Zip	Code)	
	20a. METHOD OF DISPOSITION		Ob. PLACE AND DATE	OF DISPOSI	ITION (Name of	- Canab	DATE			City or Town,	State
	1 Burial 2 Cremation 3 Rem 4 Donalion 5 Other (Specify)	noval from State	Woodlaw	n Cem	etery					, Wes	
	21. SIGNATURE OF PUMERAL SERVICE LI	CENSEE	~		INNICH			OME			
	TCACTI	Il lun	much	K I					ersto	wn. Mo	d. 21740
	23. PART I. Enter the diseases, or shock, or heart fallure.	complications that cause on	ed the death. Do	not entar	the moda of d	ying, suc	h as cardi	ac or reapli	retory arr	est,	Approximate
	IMMEDIATE CAUSE (Final	Λ		. /							Interval Between Onset and Dasth
	disease or condition resulting in death)	. Acerta	S A CONSEQUENCE O	wate	ry 7	0400	ele				1 Hz
		DUE TO (OR AS	A CONSEQUENCE O	/F): 		1		-			
RTIFICATION	Sequentially list conditions,	b. CALLIC	S A CONSEQUENCE O	ctio-	e pu	mo	var	1-0	Jea	be	Lears
TA.	If any, leading to immediate cause. Enter UNDERLYING	50E 10 (011 AL	TA CONSEQUENCE C	r-j.							
I	CAUSE (Disease or Injury that initisted events	DUE TO (OR AS	A CONSEQUENCE O	IF):							ļ
띪	resulting in death) LAST	d									
CE	PART il. Other algnificant condition	na contributing to death	but not resulting	In the up	derlying cause	aluen In	Bort I	04- 1400 041			
MEDICAL			and not reducing	in the dire	uarrying cause	given in		24a. WAS AN / PERFORI	MED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE
0							- 1	1 TYES 2	NO NO	OF	DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	FS \square N	л П пи	CERTAIN				1 [YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	LIBOTE TO CAUSE	26. PLACE OF DEA			CEKIAII					
Sic	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/O	utpetient 3 DOA	OTHER		lesidence	8 C Other	(Snecital)			
并	27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED										
ВУ	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO										
	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number,							Number,			
	4 Homicide determined							,,			
P		ICIAN: To the best of my kno									
COMPLETE	one) 2 MEDICAL EXAMINE	ER: On the beals of examinst	ion and/or investigation	on, in my op	olnion, death occu	ared at the	time, date a	and place, and	d due to the	ceuse(a) an	d manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LIC	ENSE NUM	MBER		29d. DATE	SIGNED (Mo	onth, Day, Year)
10 B	(1)0	100/4			0:	214	57		D 4/	21/0	750
ı ⊢ II	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALLSE OF	SEATH STEM OF CE	Outed					-		

MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Attack.

AVE.



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

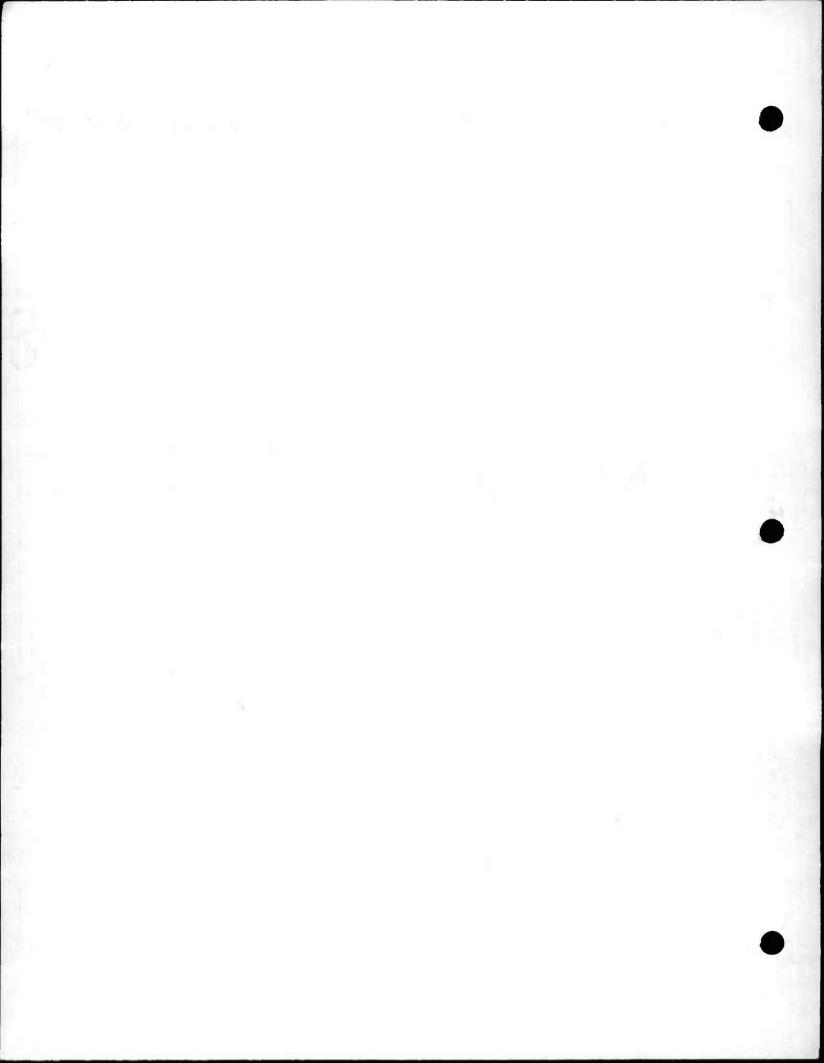
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First	I, Middle, Last)	***		114			<u> </u>	DEA		2. DATE OF DEATH		VEAR	3. TIME OF DEATH
Elizabeth Irene Harr									Hpri 19 1995 12.3				
						IF UNDER 1	YEAR DAYR	IF UNDER					
215-28-67			04			9b. CITY, TOWN OR LOCATION OF DEATH						nsylvania	
Fallston			a.l.			90. GIT, I		Fall			9c. COI		rford
RESIDENCE OF DEC	CEDENT						_						
10a. STATE	10b. COUNT			-1	loc. CITY,	TOWN OR	LOCAT		1	_			10d. INSIDE CITY LIMITS?
Maryland		larford							Edge	wood			1 - YES 2 - NO
100. STREET AND NUMBER 621 Ha		Tana					101	. ZIP CODE		040	10g. CI		HAT COUNTRY?
11. MARITAL STATUS	I LWOOD	12. WAS DECEDEN	T EVED IN I	I C ADME	0	1 42 40	0.050	THE PARTY OF		040			JSA
1 Never Married 2 🔀	Married	FORCES? 1	YES	2 - NO	U	17.3	res, sp	ecify Cuba	n, Maxican	IC ORIGIN? (Specify Y n, Puerto Rican, etc.)	ea or No—		— American Indian, White, atc.
3 Widowed 4 Divo	orced	17 165, 0176 7	AR OR DAI	ES		,,,	_ TES	2 🔀 NO	Specify:			Specify	white
15. DEC (Specify only	EDENT'S EDU	CATION completed)		18a. DECEL	DENT'S U	SUAL OCC	UPATIO	ON ast of workin	10	16b. KIND OF B	JSINESS/IN	DUSTRY	
Elementary/Secondary (0	0-12)	College (1-4 or 5	+)	life. Do	NOT use	retired.)			•				
11. 17. FATHER'S NAME (First, M	Note to the				Home	make	r			Но			
Paul Fra		roinor					8	,		ME (First, Middle, Meide Lola Hugh			
19a. INFORMANT'S NAME (rener		19b. M	AILING A	DOBESS (Street e			oute Number, City or To		In Carda)	
Eugene Harr										dgewood,			21040
20a. METHOD OF DISPOSIT 1 M Burial 2 □ Crematic 4 □ Donation 6 □ Other	on 3 🗆 Rem	oval from Stata	20b. P	ET A	DATE OF	DISPOSITI	ial	me of Gar	dens	4/22/95	Bel A	ir, N	n, State Maryland
21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	/	,		22. NA	ME AL	D ADDRES	SS OF FAC	mas III F	inora	1 Hon	no D 7
1 Sty	Muy	alku	gly			131	7 C	'okes	bury	Road, Ab	ingdo	on, Mo	21009
23. PART I. Enter the di shock, pr h	iseasea, pr (eart failure.	complications that List only one cau	caused to	the death th line.	. Do no	t enter th	ne mo	de of dyl	ng, such	as cerdiec Dr ree	olratory e	rreet,	Approximate intervel Between
IMMEDIATE CAUSE (Fir disease or condition	nal		1. 1	L	. 1		1	1	Ŧ	1 1			Onset end Deeth
resulting in death)	→	o. Cons	rol	on	sech.	576x	1 1	wi	ma	tion			24 hu.
	_	a. Incl	(OR AS A C	ONSEQUE	NCE OF):		,	0 .	MOC				36 has
Sequentially list conditi			(OR AS A C			cro	au,	ex p	1003	UVZ			, ,
cause. Enter UNDERLY!	ING	· Cer	ebr	of.	he	Mos	rl	age	2				138 hr.
that initiated events		DUE TO	(OR AS A C	ONSEQUE	NCE OF):	. 4		0					111
resulting in death) LAS		d. Hy	cen	Ehf	LON								1/245
PART II. Other eignifica	nt condition	s contributing to	deeth but	not reeu	ilting in	the unde	rlying	ceuse o	Iven in F	Part I. 24a. WAS A	NAUTOPSY	24b. 1	WERE AUTOPSY FINDINGS
											RMED?	1	AVAILABLE PRIOR TO COMPLETION DF CAUSE
										_ ' ' '	Z [K] NO		DF DEATH? 1 YES 2 NO
DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES	□ N	0 🗹	UNC	ERTAIN				
25. WAS CASE REFERRED R EXAMINER?		HOSPITAL:		. PLACE O	F DEATH	(Check onl							
1 YES 2 NO		1 De Inpatient 2	ER/Outpati	lant 3 🗆		DTHER:	g Hom	e 5 🗆 Rei	aldenca 6	Other (Specify)			
	Pending Investigation	28a. DATE OF (Month, D	INJURY ny. Year)	28	Bb. TIME (ty .	WO	URY AT RK? 'ES 2		28d. DEŞCRIBE HOW	INJURY OC	CURED	
3 Suicide 6	Could not be determined	28a. PLACE O building,	F INJURY — atc. (Specify	- At home,	farm, stre	et, tactory	, office			281. LOCATION (Street City or Town, State	and Numbe	or or Rural Ro	oute Number,
29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my knowled	ige, death	occurred	at the time	, data	and place,	and dua t	o the cause(a) and mi	nner as sta	ried,	
CERTIFFIER (Check only one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Check one) CERTIFFIER (Che													
296 SIGNATURE AND TITE	OF CERTIFIER	m 1/1	purl.	10	Da	7		29c. LICE	NSE NUME	BER	29d. DAT	E SIGNED	Month, Day, Year)
30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAUS	E OF DEATH	H (ITEM 37	1 (hora B	rint)	h. U.	PI	745	D	M	KIL /	7, 1743
HARVEY	B. PA	75 M.D.			5-17-18	DA	2.	SUIT	73 3	201 Fore	rt H	4, H.	d. 21050
31. DATE FILED (Month, Day.	995	32. REGISTRA	R'S SIGNATI	URE									
MFR G1	777	THE PARTY OF THE	HOT TON	Same.									

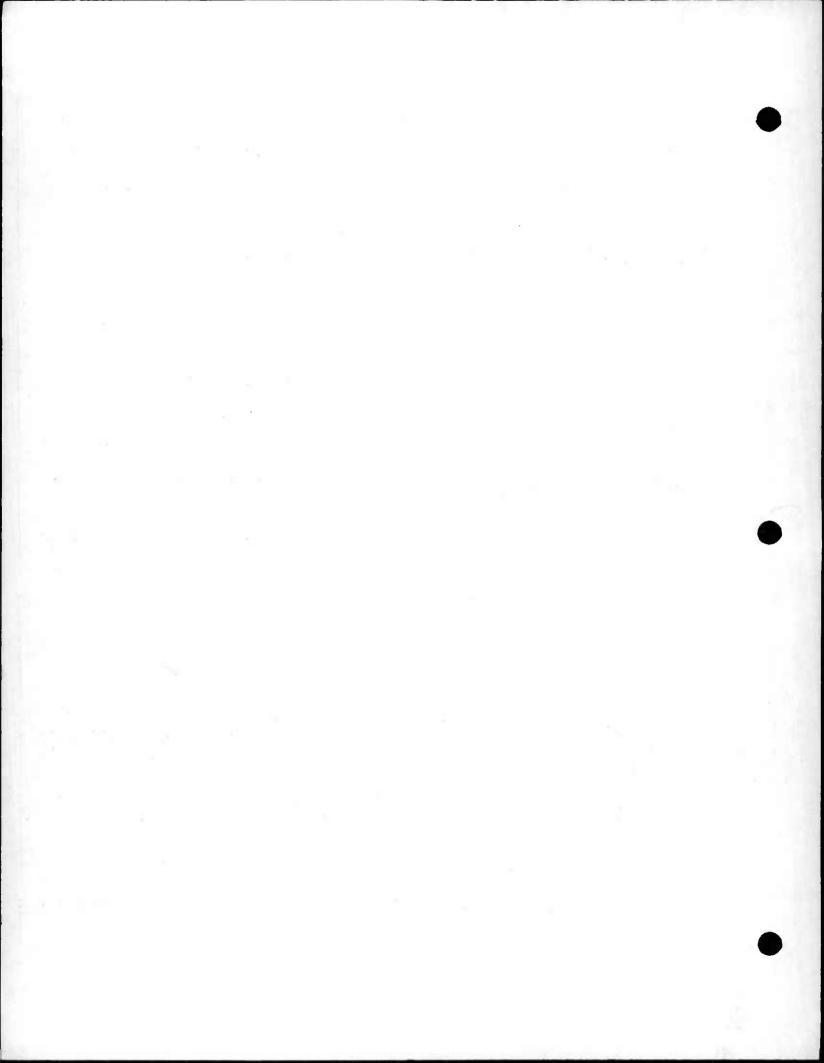
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE OF M	ARYLAND / DEPART	MENT OF HEALTH AND	MENTAL HYGIEN								
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH						
	CECELIA Jano H	000		APRIL 1	4 1995	0240 "						
	4. SOCIAL SECURITY NUMBER 5. SEX	. 7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign								
	214-10-2089 10 M 2 🔀 F	7.8 YRS.	NONTHS DAYS HOURS MIN	(Month, Day, Year) 1.0-10-1.6	Coun	**						
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF		9c. COUNTY OF	eryland						
DIRECTOR	Anne ARundel Medical Center Annapolis Anne Aru											
RE	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10											
	Maryland Anne Arunde	1 Anna	polis			LIMITS?						
FUNERAL	10e. STREET AND NUMBER		101, ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?						
ij	College Parkway Place		2140	l .	USA	4						
5		EVER IN U.S. ARMED YES 2 NO	13. WAS DECENDENT OF HIS	PANIC ORIGIN? (Specify Yes	or No- 14, RAC	E — American Indian, k, White, atc.						
ВУ	1 Never Married 2 Merried FORCES? 1 IF YES, GIVE WA		If yes, specify Cuban, Mex 1 TYES 2 NO Spi		Spec							
	Α					white						
COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY							
Ž	Elementary/Secondary (0-12) College (1-4 or 5+)	INE. DO NOT USE	reared.)									
M	1.7 17. FATHER'S NAME (First, Middle, Last)	Secret				Red Cross						
			1	NAME (First, Middle, Maiden	,							
BE	Howard Colliflower 19a. INFORMANT'S NAME (Type/Print)	Describeration of the last of		7 Helen Un								
5		I	DDRESS (Street and Number or Rui									
	William H. Hood		olly Court S									
	1 Sp Burial 2 Cremation 3 Removal from State	20b. PLACE AND DATE OF cametery, crematory or other	er place)		CATION — City or To	own, Stata						
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1 Prospect	Cemetery 4-		. Aires	MD_						
	D, K2 1		Barranco ar		noral I	Iomo						
115	Raus Comp		495 Ritchie									
	23. PART I. Enter the diseases, or complications that shock, or heart failure. List only one caus	ceused the deeth. Do no e on each line.	t enter the mode of dying, s	uch as cardiac or respi	ratory arreat,	Approximate interval Between						
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Septe Shock Due to/(or as a consequence of):											
_	DUE TU/(OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate Due to (or As A consequence or): Due to (or As A consequence or):											
A	cause. Enter UNDERLYING)	/			Ĺ						
Ē	thet initieted events	OR AS A CONSEQUENCE OF):										
ᇤ	resulting in death) LAST					<u> </u>						
	DADT II Other clantificant conditions contained as											
Ä	PART II. Other significant conditions contributing to d	eath but not resulting in	the underlying cause given	In Part I. 24a. WAS AN. PERFOR		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO						
PHYSICIAN: MEDIC				1 [] YES 2	DKN0	COMPLETION OF CAUSE DF DEATN?						
Σ						1 - YES 2 - NO						
ÿ	DID TOBACCO USE CONTRIBUTE TO CAU	SE OF DEATH YES	□ NO □ UNCERTA	UN 💆								
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE OF OEATH	(Check only one)									
YSI	1 YES 2 NO 12 inpatient 2		☐ Nursing Home 5 ☐ Residence	e 6 🗆 Other (Specify)								
H	27. MANNER OF DEATN 28a. DATE OF III	IJURY 26b. TIME (NJU)	OF 28c. INJURY AT WORK?	26d. DESCRIBE NOW IN	JURY OCCURED							
₩ I	1 Natural 5 Pending 2 Accident Investigation		M 1 YES 2 NO									
	building. et	INJURY — At home, farm, str. c. (Specify)	eat, factory, offica	28f. LOCATION (Street a City or Town, State)	nd Number or Rural I	Route Number,						
	4 Nomicide determined			,								
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat of m	y knowledge, death occurred	at the time, date and place, and d	us to the cause(s) and men	ner as stated,							
8	one) 2 MEDICAL EXAMINER: On the basis of exa					and manner ea stated.						
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE N		29d. DATE SIGNED							
B	Ruly T Peter		bay	604	D 4-1	1-5 -						
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Type, P	rint)		1-6							
	600 2 dels	tue	Annopoly	mel s.	uri							
	31. DATE FILED (Month, Day Year) 32. REGISTRAR	S SIGNATURE	11-19	- () ([4]							
	APR 21 1995 Juli Studies	rhandall										



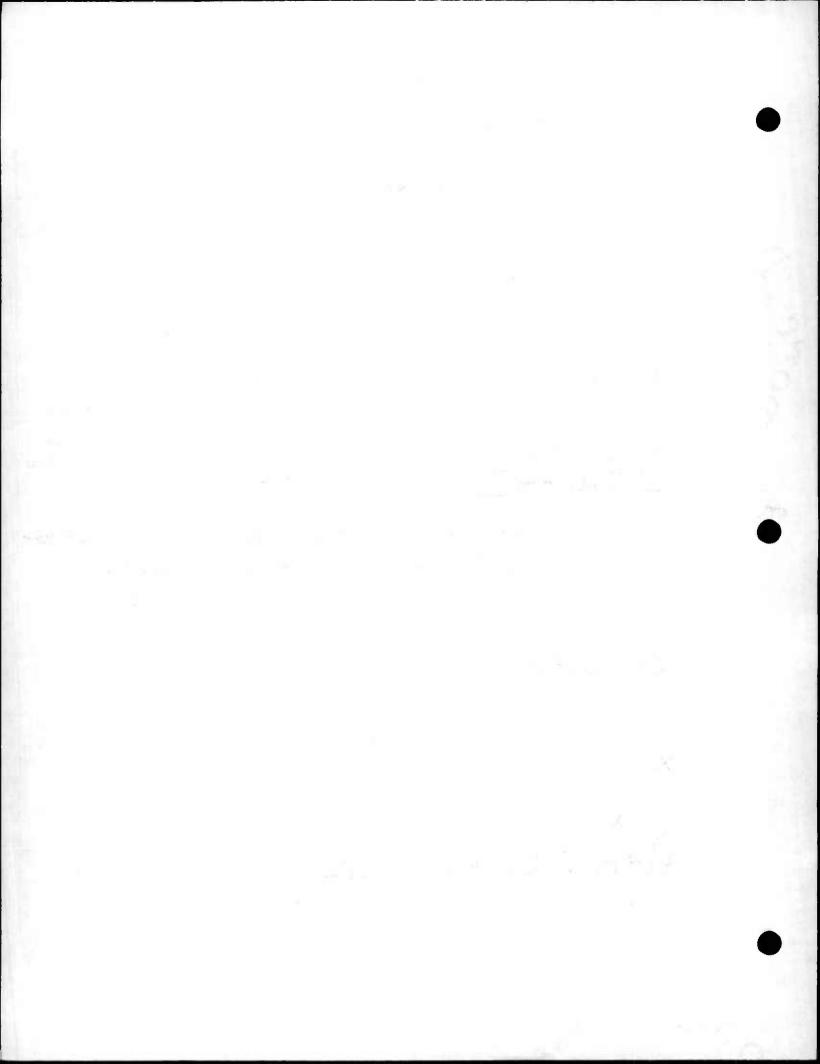
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTM	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN		3. TIME OF DEATH			
	John H. Hupp				April 14		2:45A M			
		5. SEX 6. AGE (In yrs. les	THE DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRTI	NPLACE (State or Foreign				
	216-30-9951 9s. FACILITY NAME (If not institution, give stree	1 X M 2 □ F 60	YRS.		(Month, Day, Year) NOV 23 193		t Virginia			
Œ	1248 Tyler Avenue	of and number)	9b.	CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF D				
16	RESIDENCE OF DECEDENT			Annapolis		Anne	Arundel			
DIRECTOR	10s. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION			10d. tNSIDE CITY LIMITS?			
	MD Anne A	runde l	An	napolis			YES 2 NO			
FUNERAL	1248 Tyler Avenue			101. ZIP CODE 21403		10g. CITIZEN OF	States			
N		12. WAS DECEDENT EVER IN U.S. AR	MED	13. WAS DECENDENT OF HISPAI	NC ORIGIN? (Specify Yea		E — American Indian,			
BY F	1 Never Married 2 Married	FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES	10	If yes, specify Cuban, Maxica	in, Puarto Rican, etc.)	Blac	k, Whits, etc.			
	3 Widowed 4 Divorced						White			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	(Gi	CEDENT'S USU. ive kind of work of Do NOT use net	AL OCCUPATION Jone during most of working	16b. KIND OF BUS	SINESS/INDUSTRY				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	lumber	100.)	DI	mbing				
Ö	17. FATHER'S NAME (First, Middle, Last)		Turiber	18. MOTHER'S NA	ME (First, Middle, Maiden					
BE	John W. Hupp			Marc	aret Colli	ns				
0	19a. INFORMANT'S NAME (Type/Print)	198	b. MAILING ADD	RESS (Street and Number or Rural						
	Gertrude Hupp			yler Avenue An						
	20a AFTHOD OF DISPOSITION 1 Sorial 2 Cremetton 3 Remove 4 Donation 5 Other (Specify)	at from State 20b. PLACE A competery, cre-	matory or other p	sposition (Name of Lace) Cemetery 4/17	.1	CATION — City or To				
	# SIGNATURE OF FUNERAL SERVICE-LICEN		crest	22. NAME AND ADDRESS OF FA	/95 An	naporis,	Maryland			
	HR. 0.0 d -	PV		22. NAME AND ADDRESS OF FA	John M.	laylor F	uneral Home			
- 3	23. PART I. Enter the disesses, or con	Tay To	ath De ant i	147 Duke of G						
	snock, or naart isliure. Lie	n only one cause on each line.	am. Do not a	mar the mode of dying, suc	n as cerdisc or respi	ratory arreat,	Approximate Intervsi Between Onset and Death			
	IMMEDIATE CAUSE (Finel disease or condition									
	resulting in desth) s. Metalatic lung cancer Due to (or as a consequence of):									
ž	socialistic les andilles Co. Liver metzitzies									
CERTIFICATION	If any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A CONSEC		•						
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEC	157 15 20	3.7						
ᇤ	reaulting in death) LAST		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	PART II Other elgolificent conditions of	pantalbushas to death had a	lat 4 at							
PHYSICIAN: MEDICAL	PART II. Other algolificent conditions of	contributing to deeth but not re	esulting in th	e underlying ceuse given in	Part I. 24a. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
EDI				·	1 YES 21	NO	OF DEATH?			
Σ.	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF DEA	TH VEC [□ NO □ UNCERTAIN			1 TYES 2 NO			
IAN	25. WAS CASE REFERRED TO MEDICAL		E OF DEATH (C)		4 []					
SIC		OSPITAL:		HER: Nursing Home 5 Realdence	6 Other (Specify)					
F	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED				
BY	1 Natural 5 Pending 2 Accident Investigation	B B E W	50000	M 1 YES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At hor building, etc. (Specify)	me, farm, atreet	factory, offica	28f. LOCATION (Street a: City or Town, State)	nd Number or Rural F	Route Number,			
COMPLETED	29a, CERTIFIER									
MP	(Check only 1 CERTIFYING PHYSICIA	N: To the best of my knowledge, dea								
	29b. SKINATURE AND TITLE OF CERTIFIER	On the basis of examination and/or in	investigation, in							
BE	CALL OF CENTIFIER	7 21 - M	aı	29c. LICENSE NUN	IBER	29d. DATE SIONED	(Month, Day, Ybar)			
5	30. NAME AND ADDRESS OF PERSON WHO C			DEMA	L O	1/1-	773			
	Ann C. Massey, n			ke Rd Solte	300 An	napolu, r	10416 Cu			
	APR 19 1995	32 REGISTRAR'S. SIGNATURE	-		- 1 1 31		9.151			
	ALV 19 1999	Jama dimonar hard	tally							



	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
R	CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF		MENTAL HYGIEN		10103				
	- 1	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF OEATH		3. TIME OF DEATH								
	1 3	Edwin Malb	urn Hall					1995	1:20AM M				
		4. SOCIAL SECURITY NUMBER		E (fn yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
Pi		220-44-4447		85 YRS.	MONTHS DAYS	HOURS MIN.	April 18 1	909	Illinois				
020 physician. burial-transit permit. Pages 1, 2, 3 should	DIRECTOR	99. FACILITY NAME (If not Institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH Meridian Health Care Center/Spa Creek Annapolis RESIDENCE OF DECEMENT 90. COUNTY OF DEATH Anne Arundel											
ges 1	5	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 16											
2	ᆸ	MD Anne	Arundel		Anna	polis			YES 2 NO				
Pera	IAL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF											
an. ransit	FUNERAL	1305 Van Buren				21403		Unit	ted States				
21215-0020 or attending physician. rr use as the burial-trar	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 10 YE IF YES, GIVE WAR OR		Il yes, s		NIC ORIGIN? (Specify Ye en, Puerto Rican, etc.) fy:	e or No—	4. RACE — American Indian, Black, White, etc. Specify: White				
215 attent	9	15. DECEDENT'S EDUC (Specify only highest grade	ATION	16a. OECEDENT'S	USUAL OCCUPAT	TION	16b. KIND OF BU	SINESS/INDU					
14 E	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	nost of working	United						
ND hospit	MP		6	Profe	ssor		Naval	Acader	ny				
YLAND 2121 by the hospital or attu be detached for use at once.		17. FATHER'S NAME (First, Middle, Last) Edwin Hall				1	AME (First, Middle, Maiden	.,	_				
RYL ed by t	H			Taxaban managan			_aura Malbu						
MARYLAND e retained by the hospit 5 should be detached notified at once.	일	Charles M. Grays	ton				Route Number, City or Tox		· ·				
		209. METHOD OF DISPOSITION		20b. PLACE AND DATE					yland 21403				
IORE, a 6 may be ector, page		1A Buriel 2 Cremetion 3 Remo	evel from State	cemetery, crematory or o	ther place)	motory 4	/17/05 Apr	POPOLICE	s, Maryland				
Page al dire		21. SIGNATURE OF FUHERAL BERVICE LIC	EMOCI	St. Marya	22. NAME /	AND ADDRESS OF F	CUTYLODD M	Toylo	r Europa I Homo				
BALTIMORE, affer death. Page 6 may be by the funeral director, page moval.		22. NAME AND ADDRESS OF FACILITY JOHN M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
S E S D		23. PART I. Enter the diseasea, Dr c ahock, Dr heert fellure. I	omplicetions that caus list only one cause on	sed the deeth. Do r	not enter the m	ode of dying, au	ch es cerdlec or resp	iratory arres	Approximete Interval Between				
		TO CONTRACT OF THE PARTY OF THE											
760 ed within 24 ompletely fille il, cremation, event, the		resulting in death) - e. wight the Heart Towns 3 mod											
P 2 2 4 2			Dil Ota	CONSEQUENCE OF	5000	2041	Tandital	. 44 /-	0				
8 " o F	0	immediate cause (Final disease or condition resulting in death) e											
0 2 5 E	CAT	ause. Enter UNDERLYING											
. 2 0 2	Ē	CAUSE (Disease or injury that initiated evente	DUE TO (OR AS	S A CONSEQUENCE OF	י								
O = 5 = 6	CERTIFICATION	resulting in deeth) LAST	l										
C Se S		PART II. Other eignificent conditions	contributing to deeth	but npt resulting	n the underivi	na ceuse alven in	Part I. 24a, WAS AN	AUTOPSV	24b. WERE AUTOPSY FINDINGS				
- 38 E	ICAL	Dement	a		PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
RECOF requires that een signed to of Health a	MEDIC						1 TYES :	5 XX 60	OF DEATH?				
2		DID TOBACCO USE CONTR	IBUTE TO CAUSE	S 🗆 NO [N		1 TES 2 NO						
AL has has Deg	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEAT									
VITA	Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 I ER/O	utpetient 3 🗆 DOA	OTHER:	me 5 🗆 Reeldence	8 Other (Specify)						
T 5 5 5 .	[등	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year		E OF 28c. IN	JURY AT	28d. DESCRIBE HOW I	INJURY OCCU	RED				
ON OI DING PHYS After this death with	ΒYΙ	1 Natural 5 Pending 2 Accident Investigation	(100			YES 2 NO							
ENDIN R: Af er de	ED	3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, atc. (S)	RY — Al home, larm, specify)	street, lectory, offi	lce	281. LOCATION (Street of City or Town, State)	and Number or	Rural Route Number,				
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is mai													
DIV AL OR A AL DIREC 2 hours 1 item	PL		CIAN: To the best of my known										
SPITUSPITUS INFRA 7	COMPLET	2 MEDICAL EXAMINER	t: On the basis of examinat	tion end/or investigation	n, in my opinion,	death occured at the	lime, date and place, en	d due to the d	ceuse(e) end menner ee stated,				
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	BE C	201 ATURE AND TITLE OF CENTRIER	f 4 1	P-	^	29c. LICENSE NU	MBER	29d. DATE S	SIGNED (Month, Day, Year)				
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	TO B	Teller.	Juc	our,	mu)	D1165	53	► Apr	ril 13 1995				
	-	30. NAME AND ADDRESS OF PERSON WHO		, ,,,,,,									
		Peter F. Verkouw,			Drive A	nnapolis.	MD 21401	(410-2	267-9211)				
		31. DATE APPROOF 40% 1995	34. REGISTRAR'S SIG	Mardall									



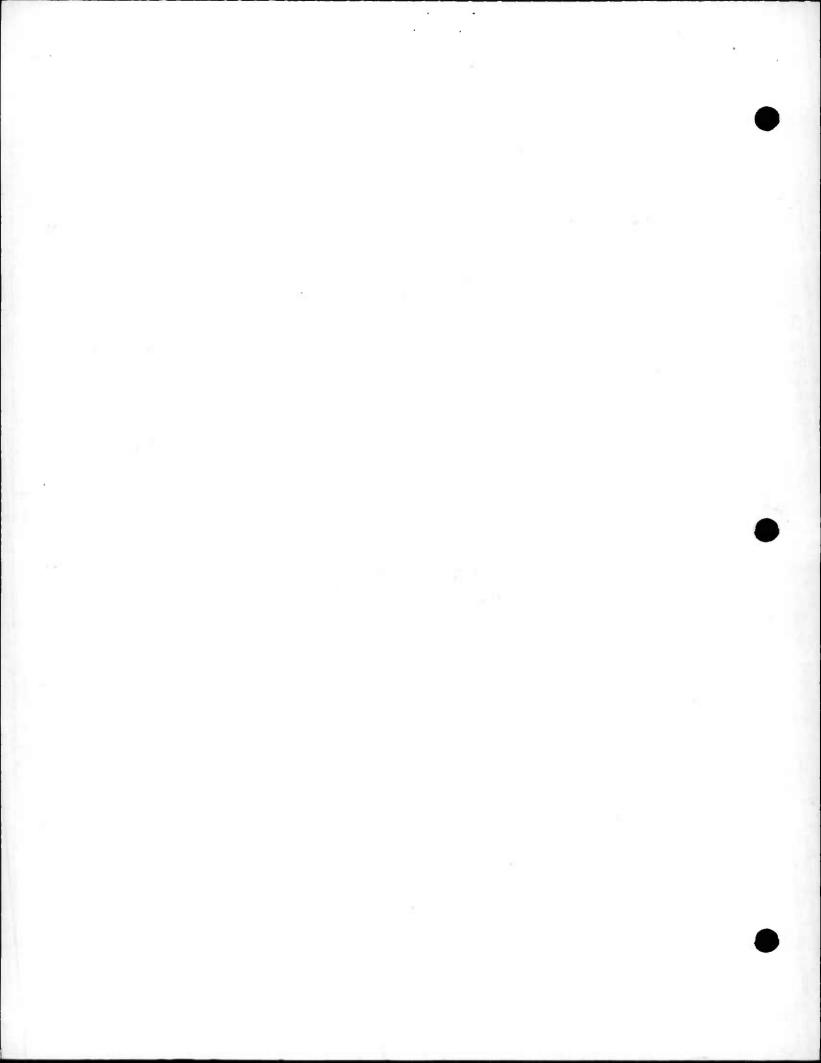
DIVISION OF VITAL RECORDS, P.O. BOX 68760

AMENDED #1 and #16B, 4/17/95, B.P., WORCESTER CO. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First 2 DATE OF DEATH 3. TIME OF DEATH Α. 455 1995 APRIL 6, 0908 4. SOCIAL SECURITY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Formice) (Month, Day, Year) - 4-19-27 133-14-7754 67 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ATLANTIC GENERAL HOSPITAL DIRECTOR BERLIN WORCESTER RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY WORCESTER BERLIN 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 735 OCEAN PARKWAY 21811 Jeath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the bunal-transit USA 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 SOO Specify: 14. RACE Bleck, - American Indien, White, etc. 1 Never Merried 2 Married WW ВУ 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) COURT OFFICER COUNTY GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sur CHRISTOPHER HUSS ETHEL at HARMAR BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LORE G. Huss 4885 OCEAN PINES BERLIN, MD. hours after death. Page 6 may be pe 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must SALISBURY CREMATORY SALISBURY, 5 Other (Specify) examiner 22 NAME AND ADDRESS OF FACILITY nel ULLRICH FUNERAL HOME BERLINA MD. completely filled in by the rial. cremation, or removal. medical 23. PART I. Enter the disasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximata ahock. or haart fallura. List only one causa on each lina Interval Between IMMEDIATE CAUSE (Final Onset and Dasth the disease or condition resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) to burial, ancer ma CERTIFICATION and Sequentially list conditions DUE TO (ON AS'A CONSEQUENCE OF) If sny, lasding to immediata cause. Enter UNDERLYING requires that the death certificate be physician prior CAUSE (Disease or Injury or other that initiated evants resulting in death) LAST Mental injury, the PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINDINGS been signed by th or, of Health and N AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 TYES 2 THO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. OR ATTENDING PHYSICIAN: The law 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL 1 | YES 2 NO npetient 2 - ER/Outpeti 4 Nursing Home 5 Residence 6 Other (Specify) marked, or the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 W Natural 5 Pending Investigation 1 YES 2 NO After th ВҰ 2 Accident 3 Sulcide 26e. PLACE OF INJURY — At home, farm, street, factory, office building. atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 8 Could not be COMPLETED DIRECTOR: after item 28 4 Homicide hours 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menr TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 has IMPORTANT: If it (Check only one) 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED, (Morgin, Day, Year) BE 16 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) trees 32. REGISTRAR'S SIGNATURE

1995

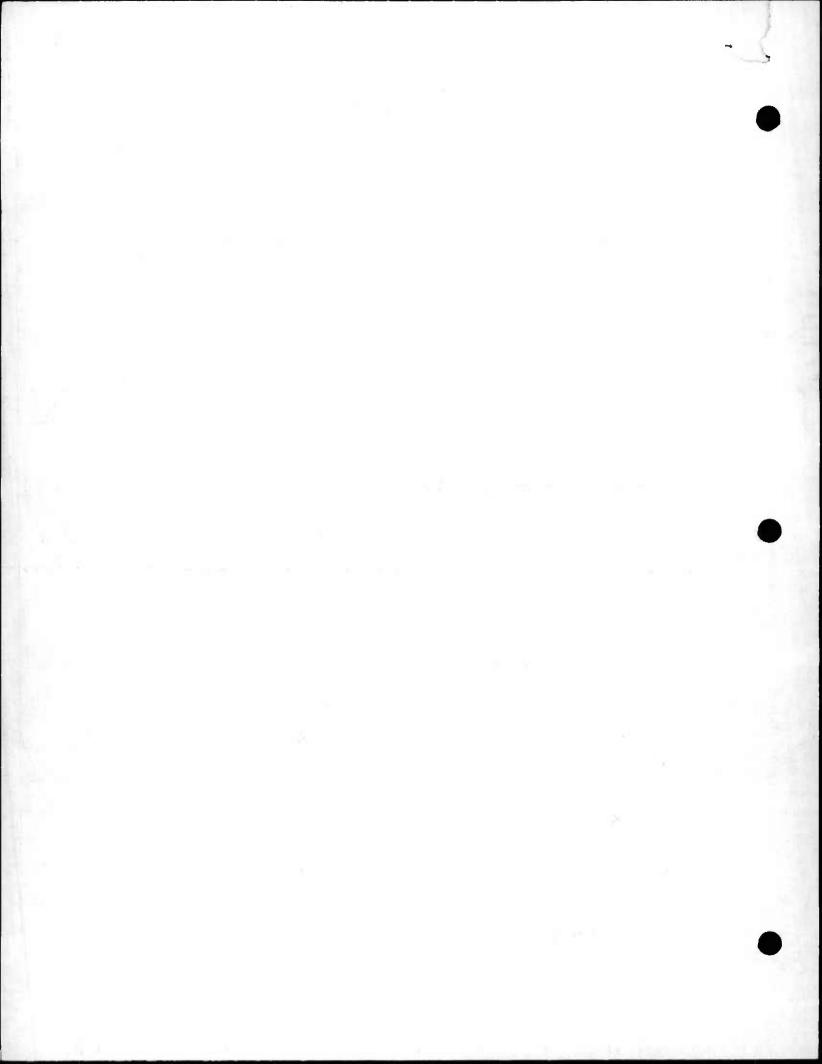
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	TIEGIOTTIAIT		CL	-niiric	JAIL	L DEVIU	ŀ	REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF			3. TIME OF DEATH	Н
		John Leonar	d Iver	cson				Apri	1 2	1 1995		744
		4. SOCIAL SECURITY NUMBER		. AGE (In yrs. lest	. Indeed to a contract of	IF UNDER 1 YEAR	IF UNDER 24 HRS					
		476-16-8908			-	ONTHS DAYS			BIRTH sy, Year)	C	IRTHPLACE (State or Fore	wign
2			1 📉 M 2 🗆 F	72	YRS.			3/15,	/1923	3 S:	ingapore	
pinous		9a. FACILITY NAME (If not institution, give a	treet and number)		9	b. CITY, TOW	N OR LOCATION OF	DEATH		9c. COUNTY C		
co.	ا د	1207 Senorita	Court			West	minster	•		Carro	211	
. 2,	l Ĕ	RESIDENCE OF DECEDENT										
Sec	Ä	10a. STATE 10b. COUNTY	1		10c. CITY,	TOWN OR LOC	CATION				10d. INSIDE CITY	
2.	DIRECTOR	Maryland Carr	:011		Wes	stmin	ster				LIMITS?	
регтіі. Pages	AL	10e. STREET AND NUMBER					101. ZIP CODE					NO
	MA I	1207 Samanita	0								OF WHAT COUNTRY?	
5-0020 anding physician. as the burial-transit	FUNER	1207 Senorita					21157				ed States	5
20 ysici	1 E	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1			13. WAS D	ECENDENT OF HISF specify Cuban, Max	ANIC ORIGIN? (S	pecify Yea o	or No— 14. F	IACE — American Indian	n,
6 g	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, OIVE WAR	OR DATES			ES 2 NO Spe		n, etc.)		manthe	
215-0020 attending physician se as the burial-trar			WWI	II			**				white	
	ETED	15. DECEOENT'S EDUC (Specify only highest grade		18a. DEC	EDENT'S US	SUAL OCCUPA	TION	16b. Kill	ND OF BUSI	NESS/INDUSTR	ry .	
2121 al or atti for use	[4]	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use r	retired.)	most of working					
<u>Q</u>	교	4		C	hemis	st		FOO	3 bc	Drug	Administ	trat
AND 2 the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					18 MOTHER'S	NAME (First, Midd			TIGHTE D	-
Y C to the to th	_	Emil Iv	rerson				Ina	VANIC (FISI, MIGG		Lemate	25	
Se de la	B		01.001.									
BALTIMORE, MARYLAND er death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. il examiliner must be notifiled at once.	일	19a. INFORMANT'S NAME (Type/Print)					t and Number or Run					
ber ge 5		<u>Hattie Louise</u>	Iverso	on 1	207 3	Senor	ita Ct.	, West	tmins	ster,	MD 21157	7
ALTIMORE, death. Page 6 may be tuneral director, page I, examiner must be	1 1	20a. METHOD OF DISPOSITION	and the second	20b. PLACEA	ND DATE OF	DISPOSITION /	Name 94/25/	O 5 DATE	20c. LOCA	ATION — City o	7 Town, State	
O Se De De De De De De De De De De De De De		1 Surial 2 Cremation 3 Remo	Ival from State	cemetery, cren	natory or other	r plece)	4/23/	مد ما است				
ALTIMO death. Page 6 funeral directo xaminer mu		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Mary	and	22 NAME	an's Ce	metery		Jurio	ck, MD	_
							tts Fur		Home	& Cha	apel	
BA Fer de the fu		KAMINER 4	ritts - Sa	wither							-	MD
B, irs after on by the removal.		23. PART I. Enter the diseases, pro	omplications that c	eused the des	th Do not	enter the m	Wasilli	top as cardian	τα.,	westi		
hours after d in by th or remove		shock, or heart fallura.	List only one cause	on each line.		Cingi tilg ti	node of dying, at	JOIT ES CATUIEC	Or respire	nory arreat,	Approximate Interval Bet	
y filled		IMMEDIATE CAUSE (Final disease or condition	0	501	0.010	Fa	VI				Onset and I	
를 들 를 +		resulting in death)	Kes	proll	7019	10	llure				12/	0
ompletel cremit event,			DUE TO (OF	R AS A CONSEO	UENCE OF):							
	z	The second of th	. Chro	nic	Mye	10921	ilure	1011	مر ما	110	15.	Vrc
	CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate	DUE TO (OF	R AS A CONSEC	UENCE OF):	0		LC 4	NIP	11-1		1.3
BOX ate be e hysician prior to	🕺	cause. Enter UNDERLYING									1	
.O. B. certificate ding physi tygiene pri	ᇤ	CAUSE (Disease or Injury that initiated events	DUE TO (OF	AS A CONSEC	HENCE OF						<u> </u>	
Signal Certific	E	resulting in death) LAST									i	
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RDS, Pat the death by the attendand Mental in y Injury, o		PART II. Other eignificant condition	a contributing to de	ath but not re	aulting in 1	the underlyi	na cause alven l	n Part I Ou		rmanev .		
RE at the at the by and and	DICAL	Tracellin Dage	indent 1	1 L hat	50.C	the discorry	ing cause given i	11 Fait 1. 24	PERFORM	ED?	24b. WERE AUTOPSY FINE AVAILABLE PRIOR TO	DINGS D
9 # 8 # E	ă	THAMIN LE LE	nuchi	PIQUE	(2)			1 [YES 2 5	(NO	COMPLETION OF CAL OF DEATH?	USE
quires quires n sign Heal									/		1 TES 2 NO	0
- A	-	DID TOBACCO USE CONTR	IBUTE TO CAUS	SE OF DEAT	H YES	□ NO T	W UNCERTA	IN []		1		
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				(Check only one						
PHYSICIAN: The this certificate h with the State Cirked, or Item	2	EXAMINER?	HOSPITAL:		0	THER:						-
ertife er	≥	27. MANNER OF DEATH	1 Inpatient 2 ER				me 5 Rasidenci					
PHYSIC this ce with the think the th	표		(Month, Day,)	Year)	28b. TIME O		JURY AT YORK?	28d. DEŞCRII	BE HOW INJ	URY OCCURED)	
NG PHYS fter this eath with	BY	1 Naturel 5 Pending 2 Accident investigation				M 1 🗆	YES 2 NO					
O S R S S	4	3 Suicide 8 Could not be	28a. PLACE OF IN building, etc.	JURY — At hom	e, farm, stre	et, factory, off	lca	281. LOCATIO	N (Street and	Number or Rur	ral Route Number,	
OR ATTENDING I OR ATTENDING I DIRECTOR: After hours after death item 28 is mai	E	4 Homicide determined	bullarily, etc.	. (Specify)				City or To	wn, State)			
OR A DIRECT HOURS	91	29a. CERTIFIER										
_ = = = = = = = = = = = = = = = = = = =	COMPLETED	(Check only	CIAN: To the best of my									
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	ō	2 MEDICAL EXAMINE	t: On the besis of axami	ination end/or in	vestigation, i	in my opinion,	death occured at If	e time, data and	placa, and o	due to the caus	e(s) and manner as stat	ted.
HT WE		29b. SWNATURE AND THE OF CERTIFIER					29c. LICENSE N	MRER	1.2	PATE SIGN	IED (Month, Day, Year)	
	B	1 to Sho	ner mo				1071	310	I 1	- Aa	21, 1995	5
66%₹	9	30. NAME AND ADDRESS OF PERSON WHO		DF DF	-7.5		1001	110		F 17 F	11111	
		114 11 =31		JF DEATH (ITEM	-		. 1	4 41	. 1			
			rer mp	394	1 14	errar	a Dr.	Wh	eato	MI, K	10 2090	6
		31. DATE FILED (Month, Day, Year)	22. REGISTRAR'S	SIGNATURE				-				
_	- 1	APR 2 4 1995	Jalia Dhude	a- 6. 0	. 0							- 1



Pages 1, 2, 3 should

permit.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hura-transit
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE

2

30, NAME AND ADD O. Haye

31. DATE FILED (Month, Day, Year) APR

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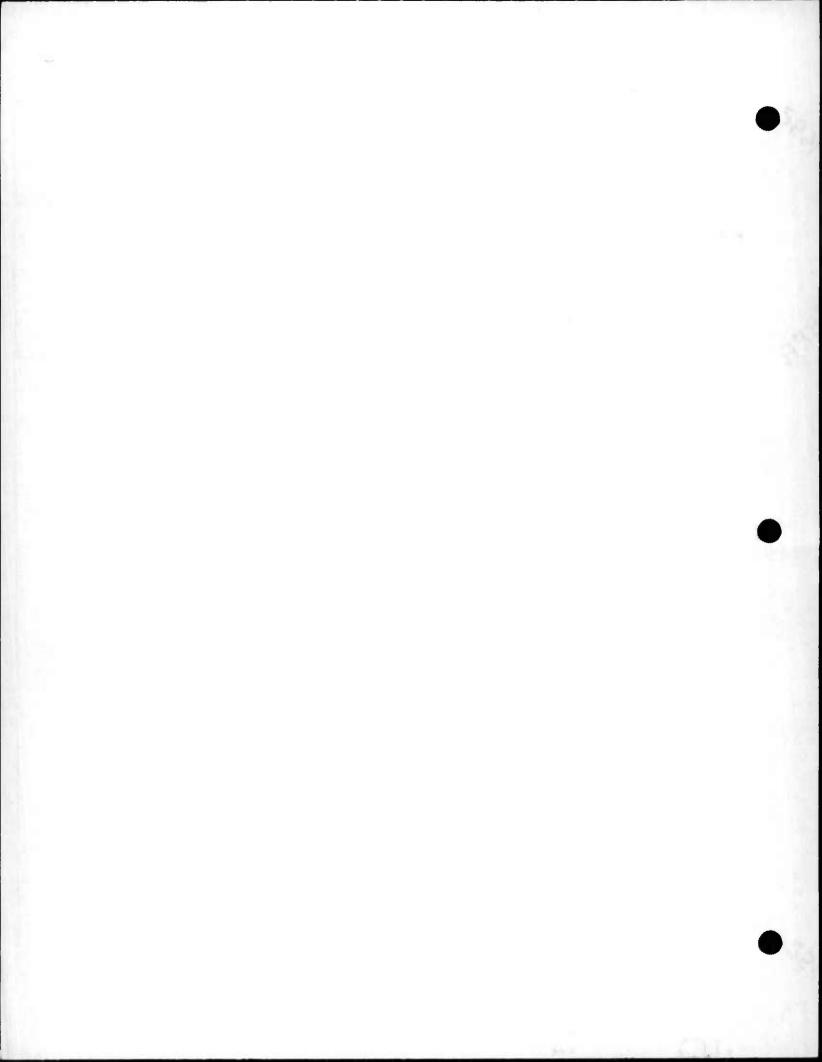
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1995

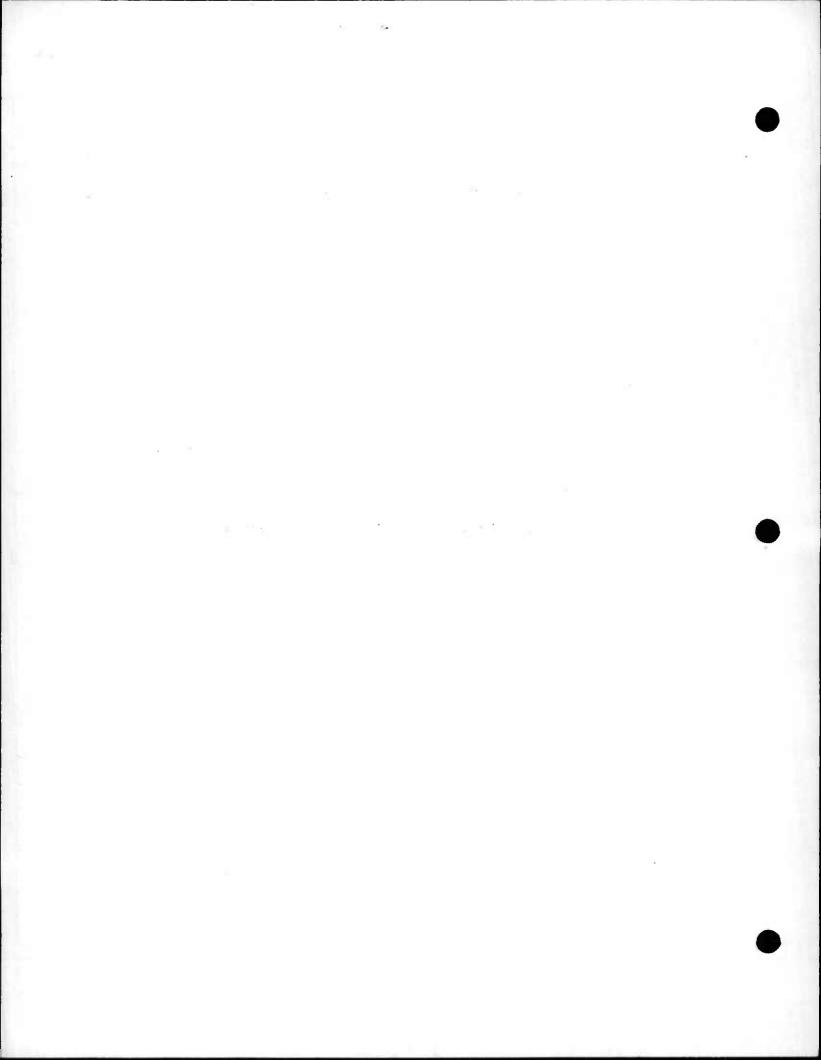
95 13772 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Julia April 7, Isaacs 9:44 A M 4. SOCIAL SECURITY NUMBER 1915 Country) Newberry 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 239-14-4445 1 🗌 M 2 💢 F 80 YRS January29 S. Carolina 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Southern Maryland Hospital Clinton Prince Georges RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Upper Marlboro 1 - YES 2 - NO 10e. STREET AND NUMBE FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3803 Halloway Circle 20772 USA 12. WAS OECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 No Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married В Specify: BLACK 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18s. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 9th Presser Laundry 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Pope Stout BE Rosa Lee 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 9 Irene Washington 3803 Halloway Circle, Upper Marlboro, MD. 9 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Harmony Memorial Park 4/15/95 Landover, MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th St. N.W. Wash, DC. 20010 (3. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. intervai Batween IMMEDIATE CAUSE (Final Onset and Death the diseese or condition resulting in daeth) Aspiration Pneumonitis 12hor OUE TO (OR AS A CONSEQUENCE OF): Peripheral Vascular Disease CERTIFICATION Months Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): it sny, leeding to immediate ceuse. Enter UNDERLYING COPD CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending м В 1 YES 2 NO 2 Accident Investigation 3 Suicide 26a. PLACE OF INJURY — At home, farm, streat, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide datarmined 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES

	D26352	29d. DATE SIGNED (Month, Day, Year) ▶ April 7, 1995
OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Piscataway Road, Clir	nton, Maryland	20735
32. REGISTRAR'S SIGNATURE Julia Davidson Randall		
		DHMH-16 Rav 1

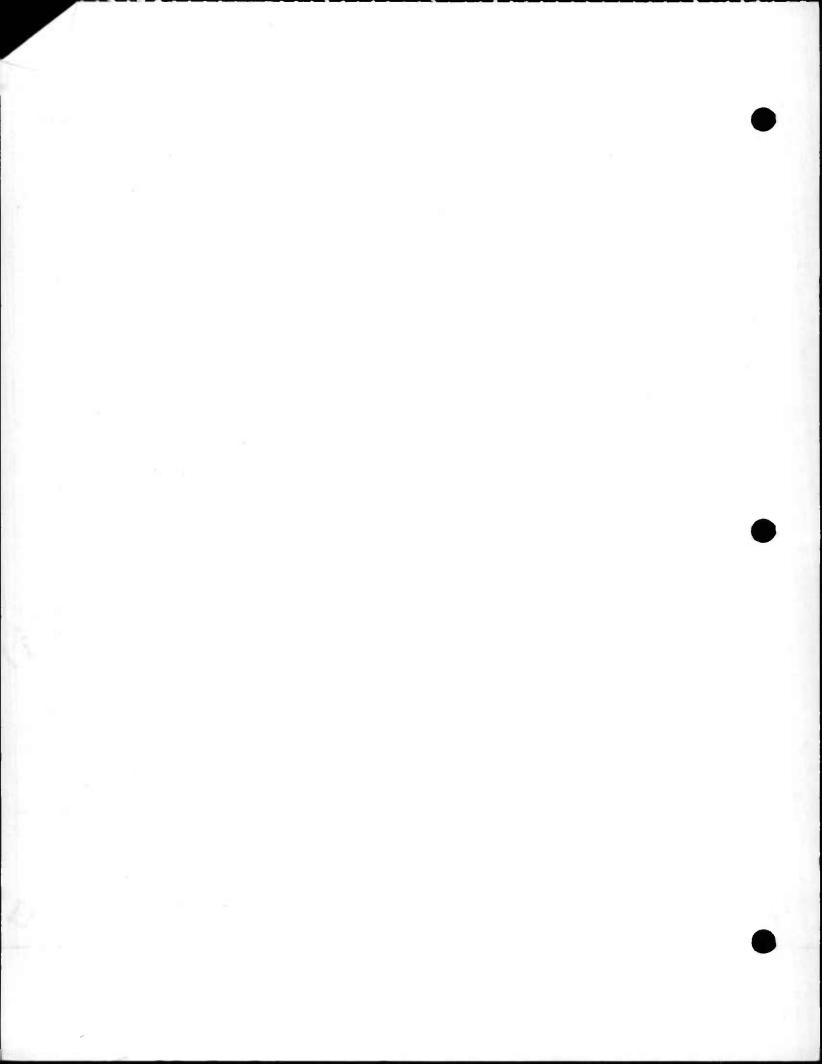


		1 - STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPART	IMENT OF CATE OF	HEALTH A	ND MENT			0 1	0110
		1. DECEDENT'S NAME (First, Middle, Last)	urles Jo	host	700	Sc.	- DEALF	2. DA	REG. NO	AY	9 3. TI	ME OF DEATH
121		4. SOCIAL SECURITY NUMBER 216–24–8829	1 💢 M 2 🗆 F	AGE (In yrs. les		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HOURS A	HRS. 7, DA	TE OF BIRTH onth, Day, Year) Y 1, 19	6		E (State or Foreign
2, 3 should	стоя	90. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				96. COU HOVE DE Grace						
Pages 1.	DIRECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y		10c. CITY,	TOWN OR LOC					10d.	INSIDE CITY
permit. P.		Maryland 100. STREET AND NUMBER	Harford		Ab	erdeen					MX.	LIMITS? YES 2 NO
120	ERAL	53 Swan Street				Ι,	01. ZIP CODE 21001				N OF WHAT	OUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 □ Never Merried 2 ★ Merried 3 □ Widowed 4 □ Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 ☑ YES 2 [IF YES, GIVE WAR OR DATES KOrea				If yes, s		IISPANIC ORIGI	GIN? (Specify Yes to Rican, atc.)			nericen Indien, le, etc.
7275 or attend use as	ETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. DE	CEDENT'S U	JSUAL OCCUPAT ork done during n	TION nost of working	1	66. KIND OF BUS	SINESS/INDUS		<u>e</u>
ND ZI hospital or ached for u	립	Elementery/Secondery (0-12)	College (1-4 or 5+)	13-7		seman			U.S. G	overn	nent	
A Se Se		17. FATHER'S NAME (First, Middle, Last)							t, Middle, Malden	Surneme)		
mAHYL retained by to 5 should be notified at	TO BE	Frederick Johns 190. INFORMANT'S NAME (Type/Print)	con	191	. MAILING	ADDRESS (Street			 Lewis Imber, City or Town 		ode)	
d)	F	Mrs. Mabel C. Jo	ohnston	P					deen, M			
. Page 6 may by ral director, page		1 1 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cometery crea	matery or oth n Ceme	F DISPOSITION (P ler place) etery	leme of		/24 Del	cation – ch ta, Pe		
SAL r death re fune al.		22. NAME AND ADDRESS OF FACILITY Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001—3399 23. PART I. Enter the diseases, or complications that ceused the death. Do not antar the mode of dying, such as cardisc or raspiratory arrest, Approximate										
filled in ton, or re		23. PART I. Enter the diseases, or shock, or heert feiture. IMMEDIATE CAUSE (Finsi disease or condition resulting in desth)	RPMN Tu	MIN Ine.	La	ioplas	ode of dying,	, such as co	TUFFYAN	ratory arres		Approximate Interval Between Onset and Death
P 0 2 0	z		b	AS A CONSEC	IUENCE OF)	:			1			
ficate be execut physician and o ne prior to buri	САТІО	Sequantisily list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEC	UENCE OF)	:						
h certification of other	ERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST										
	AL CI	PART II. Other significant condition	s contributing to dea	th but not re	suiting in	tha undarlyli	ng cause give	en in Part i.	24a. WAS AN PERFOR			AUTOPSY FINDINGS ABLE PRIOR TO
The law requires that the law been signed by ite has been signed by ite bept, of Health and em 23 shows any in	MEDICA								1 TES 2	- /	OF DE	LETION OF CAUSE EATH?
AL NEC e law requires has been sign Dept. of Heal	N: N	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	TH YES	NO [UNCER	TAIN 🗆			10	YES 2 NO
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		- La		MCall	Men	Man /
ATTENDING PHYSICIAN: The SCTOR: After this certificate s after death with the State 128 Is marked, or Item	РНҮ	27. MANNER OF OEATH 1 Netural 5 Pending	28e. DATE OF INJU	JRY	28b. TIME	OF 28c, IN	JURY AT ORK?		her (Specify) ESCRIBE HOW II	WILL OCCU		HISPUM
OING After death	D BY	Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF IN.	JURY — At hor	ne, ferm, str		YES 2 N		OCATION (Street a	and Number or	Rural Route N	umber
OR ATTENDING PHYS DIRECTOR: After this o hours after death with	ш	4 Homicide	building, etc.	(Specify)				Ci	ty or Town, State)			3111201,
TO THE HOSPITAL OR A TO THE FUNERAL DIRECT De filed within 72 hours IMPORTANT: If item	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the beat of my f									nanner ea stated.
TO THE H TO THE FI Se filed w	BE	296. SIGNATURE AND TITLE OF CERTIFIED	im/D				29c. LICENSE	E NUMBER		29d. DATE S	IGNED (Month	, Day, Year)
0=	TO	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	F DEATH (ITEM	127) (Type, P	GRME	m	210	7-5	-		
		31. DATE FILEO (MONIN, Day, Year) APR & 4 1995	Java Davel		all	1 10 0 0			- 6			



Pages 1, 2, 3 should Holy Cross Hospital DIRECTOR RESIDENCE OF DECEDENT 10h COUNT 10c, CITY, TOWN OR LOCATION Maryland Montgomery permit. 10e. STREET AND NUMBER FUNERAL 15104 Hildegard Lane transit retained by the hospital or attending physician, 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 funeral director, page 5 should be detached for use as the burial-1 Never Married 2 Married BY 3 X Widowed 4 Divorced 8 15. DECEDENT'S EDUCATION (Specify only high Ш Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10 Printer notified at once. 17, FATHER'S NAME (First, Middle, Last) Raymond Case 19a. INFORMANT'S NAME (Type/Print) 2 Charlotte A. Gatton after death. Page 6 may be pe 20s. METHOD OF DISPOSITION
1 ABurial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) must Parklawn Cemetery examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ysician and completely filled in by the prior to burial, cremation, or removal. the medical ahock, or heart fallure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition reaulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): the attending physician. Mental Hygiene prior to . Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, MEDICAL Health and N shows any has been s Dept. of H **PHYSICIAN**: 23 HOSPITAL OR ATTENDING PHYSICIAN; The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) DIRECTOR: After this certificate I hours after death with the State HOSPITAL OTHER: 1 TYES 2 NO ☑ Inpatient 2 ☐ ER/Outpetlant 3 ☐ DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF marked, 1 Natural 5 Pending М BY 2 Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, offica building, atc. (Specify) 3 Suicide 93 COMPLETED 8 Could not be 200 4 Homicide item 29a, CERTIFIER TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 he IMPORTANT: If its 29b. SIGNATURE AND TITLE OF CENTIFIER BE 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael mcoln 10313 Georgia Ave MO 32. REGISTHAR SUGNATURE RANGE I 8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 6:58 A Frances A Jenkins April 16 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdey IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Formion IF UNDER 24 HRS. Feb. 24, 72 578-22-4684 1 M 2 X F 1923 Maryland 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Silver Spring Montgomery 10d. INSIDE CITY Silver Spring 1 YES 2 X NO 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20905 USA 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarlo Rican, atc.) 14. RACE — American Indian, Black, White, atc. 1 YES 2 X NO Specify: Specify: White 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Printing 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophia Moore 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15104 Hildegard Lane, Silver Spring, MD 20905 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 4/19/95 Rockville, MD 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, INc. 500 University Blvd.W. Sil.Spr. MD 20901 23. PART I. Enter the diseases, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death acute inferior will mocordal interchan 30 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 | YES 2 - 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 4 Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as ateted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 029293 4/14/95 MD Silver Spring 20902



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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEF	PARTMEN	T OF H	EALTH DEAT	AND MI	ENTAL HYGIEN			
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	Mada	E.	20 / K	1500	7			DOC 1	AY L	YEAR	8:042M
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birtho	-		IF UNDER	24 HRS. 7	OATE OF BIRTH		8. BIRTHI	PLACE (State or Foreign
	216-50-8111	1 🔀 M 2 🗆 F	47 YR	S. MONTHS	DAYS	HOURS	MIN. J	(Month, Day, Year)	nessee		
	9e. FACILITY NAME (If not institution, give a	street and number)		9b. CIT	, TOWN O	R LOCATIO	N OF OEAT		ATH		
DIRECTOR	Holy Cross Hosp:	ital		S	ilve	r Spr		Montgomery			
Ä.	10e. STATE 10b. COUNT		10c.	CITY, TOWN	OR LOCAT	ION	_				10d. INSIDE CITY
ā	Maryland Mon	tgomery		Silve:	c Spi	ring				- 1	LIMITS?
AL	10e. STREET AND NUMBER				101.	ZIP CODE			10g. CIT		HAT COUNTRY?
EB	7 Normandy Drive	e				2090	1		II:	SA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE		13.	WAS DECI	ENOENT OF	F HISPANIC	ORIGIN? (Specify Ye			— American Indian
BY F	1 Never Married 2 🔀 Merried 3 Widowed 4 Divorced	FORCES? 1 Y			If yes, spe	2 X NO	, Mexican, I	Puerto Rican, etc.)		Black, Specify	- American Indian, White, etc. White
유	15. OECEOENT'S EDU	CATION	16a. OECEOEN	IT'S USUAL O	CCUPATIO	- IN		16b. KINO OF BU	SINESS/IN		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind	of work done OT use retired.)	during mos	st of working	2				
립	, , , , , , , , , , , , , , , , , , , ,	4	Pro	grame	c			Compu	ters		
S	17. FATHER'S NAME (First, Middle, Last)			0		18. MOTH	ER'S NAME	(First, Middle, Malden			
Ш	Robert E. Johnso	on						A. Richar			
00	19e. INFORMANT'S NAME (Type/Print)		19b. MAIL	JING ADDRES	S (Street or			ite Number, City or Tox		n Codel	
5	Alice A. Wade							ver Sprin	g, MI	20	901
	20e. METHOO OF OISPOSITION 1	oval from State	206. PLACE ANO OA cametery, cremetory Gate of	or other place) Heave	n Cei	_{me of} meter	v 4/	OATE 20c. LC 20/95 Sil	cation -	Sprin	rn, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE					S OF FACIL			op-11	6,
	* Bobert	Kam	sey	50	ranc 00 Ur	cis J niver	. Col	llins Fun Blvd.W.	eral Sil.s	Home	, Inc. D 20901
	23. PART I. Enter the diseases, or o	complications that cau	sed the death. D	o not enter	the mod	de of dyln	ng, auch e	a cardiac or reap	Iratory er	rest,	Approximate
	shock, or heart fallure. IMMEDIATE CAUSE (Final	List only one cause of	n dach lina.		~ ~						Interval Between Onset and Death
	disease or condition	a.c	lina	100m	- Re	D	de	aut D	vi C c	0.0	Oliset sild Beatil
	resulting in death)	DUE TO (OR A	S A CONSEQUENC	E OF):			,		7- 8-3-	COL MAN	
NO	Sequentially list conditions,	b									1
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	00E 10 (OR A	S A CONSEQUENC	E OF):							
Ē	CAUSE (Disesse or Injury that initiated events	OUE TO (OR A	S A CONSEQUENC	E OF):							
R	resulting in death) LAST	d.									
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MEDICAL	PART II. Other significant condition	s contributing to deat	h but not rasulti	ng In tha ur	idariying	cause gi	iven in Pa	PERFOR	RMEO?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä											OF DEATH?
=	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH	YES 🗆	ио П	UNCE	RTAIN	'nl			
¥	25. WAS CASE REFERRED TO MEDICAL	7.2.7.7.7.7.002	28. PLACE OF C			UITCL					
Sic	EXAMINER?	HOSPITAL:		OTHE	3:			T au Control		*	
PHYSICIAN:	27. MANNER OF CEATH	28a. OATE OF INJUR		TIME OF	28c. INJU			Other (Specify) 8d. OEŞCRIBE HOW I	N H IBY OO	CUREO	
	1 Natural 5 Pending	(Month, Day, Yea		INJURY	WOR			os. Organide now I	HOURT OC	COREO	1.0
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJU	JRY At home for	m street fact		-9 4		H LOOMING (C.			
	4 Homicide 6 Could not be determined	building, etc. (S	Specify)	···, anwei, 1901	ory, ornice		20	6f. LOCATION (Street of City or Town, Stete)	erid Number	or Hurai Ro	ute Number,
9	29e. CERTIFIER										
COMPLETED	(Check only	CIAN: To the bast of my kn R: On the basis of examina	nowledge, death occ stion end/or investig	curred at the t	lme, date o	end place, o	end due to	the cause(e) end me e, date end place, en	nner ee stat	ted. ne cause(e)	end manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER										
8	2 C	0		med	-	ZWC. LICEN	SE NUMBE	H '	29d. OAT	E SIGNEO	Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF	OFATH (ITEM 27)	ima Orivi) مید	S. C.	OT (12 Set	1 16 (1
	The same of the same	OL	(· ! Em 2/) (/	ypa, rinn)							The seal

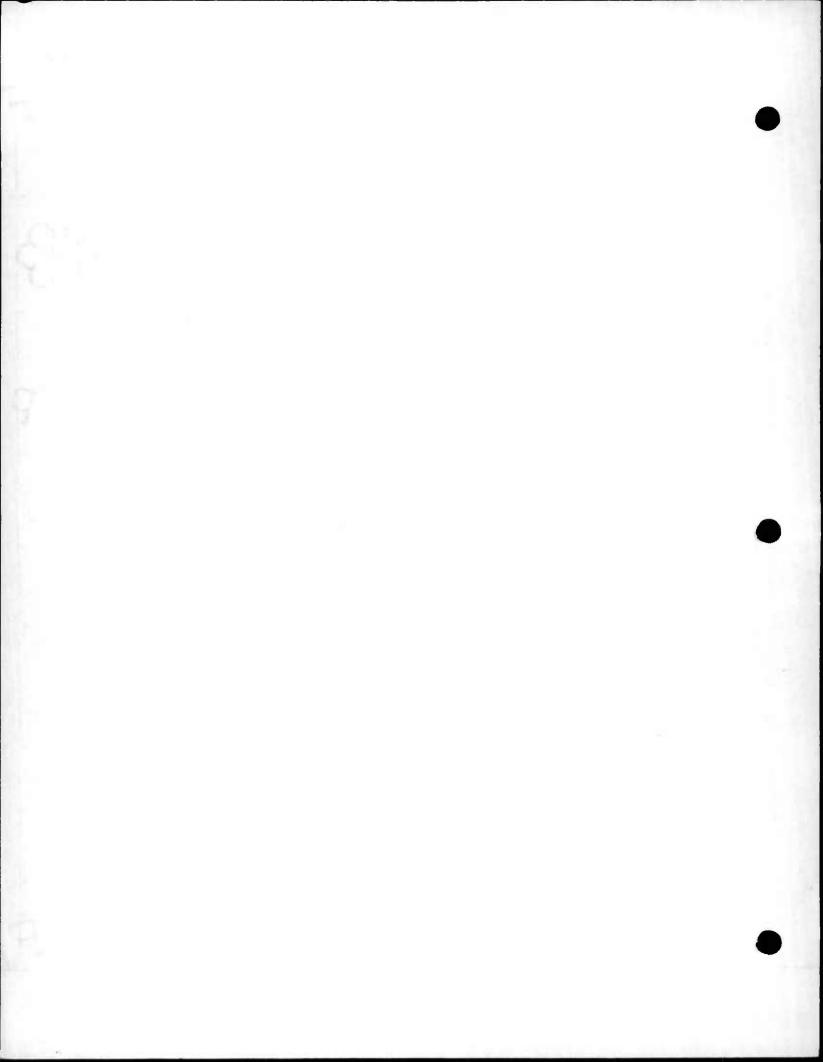
718 WISCONSIN

32. REGISTRAR'S SIGNATURE
Julia Davidson Randall

31. DATE FILEO (Month, Day, Year)

APR 20 1995

Acre



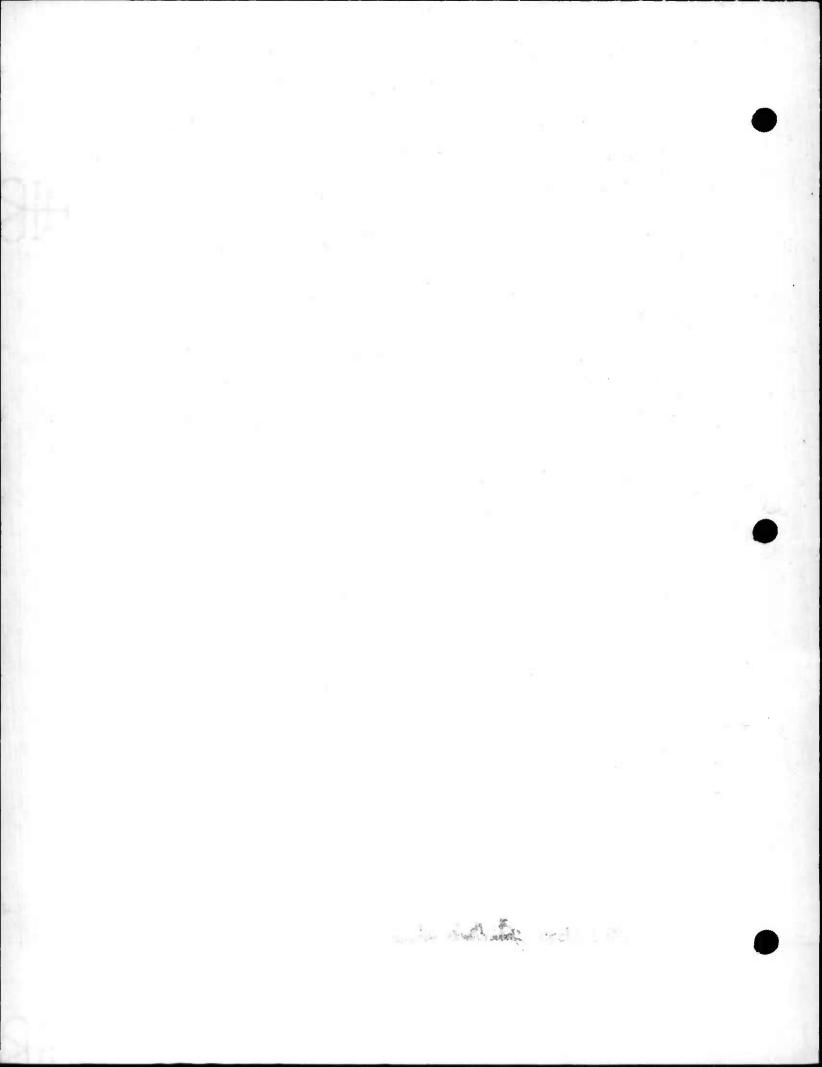
Amended #1, KB, 4-17-95, Wash-Co-Hoalgt 13776

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

								CAIL								
- 1	3	1. DECEDENT'S NAME (First, Middle, L	est)									2. DATE	OF DEATH	w	YEAR	3. TIME OF DEATH
		Janet VCIN J)NE	S								Apr		199	5	5:15 p M
		4. SOCIAL SECURITY NUMBER	П	5. SEX	6. AGE (In	n yrs. last i		IF UNDER 1			ER 24 HRS.	7. DATE	OF BIRTH		O. BIRTH	HPLACE (State or Foreign
		577-38-5539		1 M 2 F		96	YRS.	AONTHS	DAYS	HOURS	MIN.		. 26,	1898	Per	m nsylvania
		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT														
9	5	Avalon Manor N	lur	sing Hon	ne		Hagerstown						Washington			
18	5	RESIDENCE OF DECEDENT	·					inagei	3 0	OWIT				[Wasi	ning	LOII
DIBERTOR	¥	10a. STATE 10b. CO	JNTY				10c. CITY,	TOWN OR	LOCAT	TION						10d. INSIDE CITY LIMITS?
_ I -	11.		shi	ington				Hage	rst	own						1 YES 2 NO
1 3	\$ 1	10e. STREET AND NUMBER							101	ZIP CO	DE			10g. CIT	IZEN OF V	WHAT COUNTRY?
ij		2309 Grandview	Di	rive						21	740				U.S.	Α.
I NEO A	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARM	ED	13. W	S DEC	ENDENT	OF HISPAN	VIC ORIGIN	? (Specify Yes	or No-	14. RACI	E — American Indian, k. White, atc.
2		1 Never Merried 2 Married 3 Widowed 4 Divorced		IF YES, GIVE V							Specify		mean, are.;		Spec	lty:
	- 41	21														White
Once.	4	15. DECEDENT'S (Specify only highest g				(Give	EDENT'S U e kind of wo Do NOT use	rk done du			ung	16b.	KIND OF BUS	SINESS/IND	DUSTRY	S
"		Elamentary/Secondary (0-12)		College (1-4 or 5	·											
9 3	Ě	12 17. FATHER'S NAME (First, Middle, Last		5		Jener	ral A	ccou	nti				deral		rnme	nt
5 5	- 10												fiddle, Maiden	Sumame)		
ed a	4	William Crawfo	rd			_					nnah					
1	2 ∥	19a. INFORMANT'S NAME (Type/Print)				- 1							er, City or Tow			
e		Antionette V.	Lie	ght							rive	Hag	erstov	m, M	d. 2	1740
nst		20a. METHOD OF DISPOSITION 1 © Burlel 2 Cremation 3 0		val from State	come	teny crem	AD DATE OF	or olece)				1	20c. LO	CATION -	City or To	own, State
E	- 1	4 Donation 6 Other (Specify)			_ Ev	reret	tt Ce	mete	ry		4-17	-95	Ever	ett,	Pen	nsylvania
를		21. SIGNATURE OF FUNERAL SERVICE	E LICE	INSEE /	n			268.2	ME AN	oh I	ess of fa	CILITY	om o			Washington and Street
exa	- 4	CNO	1	7//	1161	RK	11.							onat	01.100	MJ 217/0
lcal		23. PART i. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														
med		shock, or haart failu	re. L	iat only one cau	use on aar	ch lina.					,,		rao or raupi	rator y arr	out,	interval Between
를 다	- 11	IMMEDIATE CAUSE (Final disease or condition														
eut,	H	resulting in death) But TO (OR AS A CONSEQUENCE OF):														
2				DUM: TO	OR AS A	CONNECT	IFRCE OF		-	-	3.0	~~				p me
41 7	. 1			DUE TO	(OR AS A											p mic
natic	25	Sequentially list conditions,	Г ь		(OR AS A C	<	com				20	nne	~~			7-
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her traumatic	אוסוועמייי	If any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury	с.	DUE 10		COMSEQU	IENCE OF	w	A	ست	20	nne	m	la s	rin	7-
or other traumatic	אוסוועמו ווייי	if any, leading to immediata cause. Entar UNDERLYING	c.	DUE 10	(OR AS A	COMSEQU	IENCE OF	w	A	ست	20	nne	m	le de	rien	7-
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injury, or other traumatic	۱ د اا	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	e.	DUE TO	(OR AS A C	CONSEQU	JENCE OF)	uy	A.	et.	7 D		24a. WAS AN	AUTOPSY	_	. WERE AUTOPSY FINDINGS
any injury, or other traumatic event, the medical examiner must be notified at once.	۱ د اا	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evanta resulting in death) LAST	e.	DUE TO	(OR AS A C	CONSEQU	JENCE OF)	uy	A.	et.	7 D			AUTOPSY MED?	_	D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
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28 Is marked, or item 23 shows any injury, TED RV DHYSICIAN: MEDICAL CI	ELEO DI TRISICIAN. MEDICAL C	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions are supported by the condition of the conditio	on be d	DUE TO DUE TO Contributing to Contributing to Lineariest 2 [28a. DATE Of [Month, D.] 28a. PLACE Of building, D.]	death bu ER/Outpet ENJURY atc. (Specifi	consequence at not res	DOA 28b. TIME INJU	OTHER: Nursin OF Nursin eet, fector	26. PL 26. PL WO 1 U y, office	ACE OF a 5 F URY AT RK? fES 2 and place	givan in DEATH (Che Residence NO	Part i. eck only one 0 Other 28d. DES 26f. LOC/City of	24a. WAS AN PERFOR 1 YES 2 (Specify) CRIBE HOW II ATION (Street a per Town, State)	AUTOPSY MED? NJURY OCCURRED NUMBER NOTE AN ARTHUR NUMBER NOTE AND ARTHUR NUMBER NOTE AR	CURED or Rural F	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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PORTANT: It item 28 is marked, or item 23 shows any injury, RF COMPI FTED RY DHYSICIAN MEDICAL	O BE COMPLETED BY PRINCIPAL O	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions and the condition of the cond	be d HYSICI	DUE TO DUE TO Contributing to Contributing to Contributing to Contributing to Contributing to Complete 2 [Complete 2 [Complete 2 [Complete 3 [Complete 4 [Complete 5 [Complete 5 [Complete 6 [Complete 6 [Complete 6 [Complete 7 [death bu ER/Outpat ER/Outpat FINJURY atc. (Specifi my knowle xemination	consequent and reserve and/or im	DOA DOA DOA DO DO DO DO DO DO DO DO DO DO DO DO DO	tha under the time of the time in my optimit)	26. PL 26. PL WO 1 U y, office	and place eath occi	givan in DEATH (Cho Residence NO Residence see, and due ured at the CENSE NUM (80)	Part i. B Chert City of to the ceu time, data	24a. WAS AN PERFOR 1 □ YES 2 1 □ YE	AUTOPSY MED? NJURY Occurred Number as stated due to the 29d. DAT	CURED or Aural F	D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and mennar ea stated. 0 (Month, Day, Year)
PORTANT: It item 28 is marked, or item 23 shows any injury, RF COMPI FTED RY DHYSICIAN MEDICAL	O BE COMPLETED BY PRINCIPAL O	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions are also as a series of the conditions of the	on be d HYSICI	DUE TO DUE TO CONTributing to CONTRIBUTION CONTRIBUTION COMPLETED CAU 32. RESTRICT CONTRIBUTION COMPLETED CAU 32. RESTRICT CONTRIBUTION COMPLETED CAU 32. RESTRICT CONTRIBUTION COMPLETED CAU 32. RESTRICT CONTRIBUTION CONTRIB	death bu ER/Outpat ER/Outpat FINJURY atc. (Specifi my knowle xemination	consequent and reserve and/or im	DOA 28b. TIME INJU	tha under the time of the time in my optimit)	26. PL 26. PL WO 1 U y, office	and place eath occi	givan in DEATH (Cho Residence NO Residence see, and due ured at the CENSE NUM (80)	Part i. B Chert City of to the ceu time, data	24a. WAS AN PERFOR 1 □ YES 2 1 □ YE	AUTOPSY MED? NJURY Occurred Number as stated due to the 29d. DAT	CURED or Aural F	D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and mennar ea stated. 0 (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

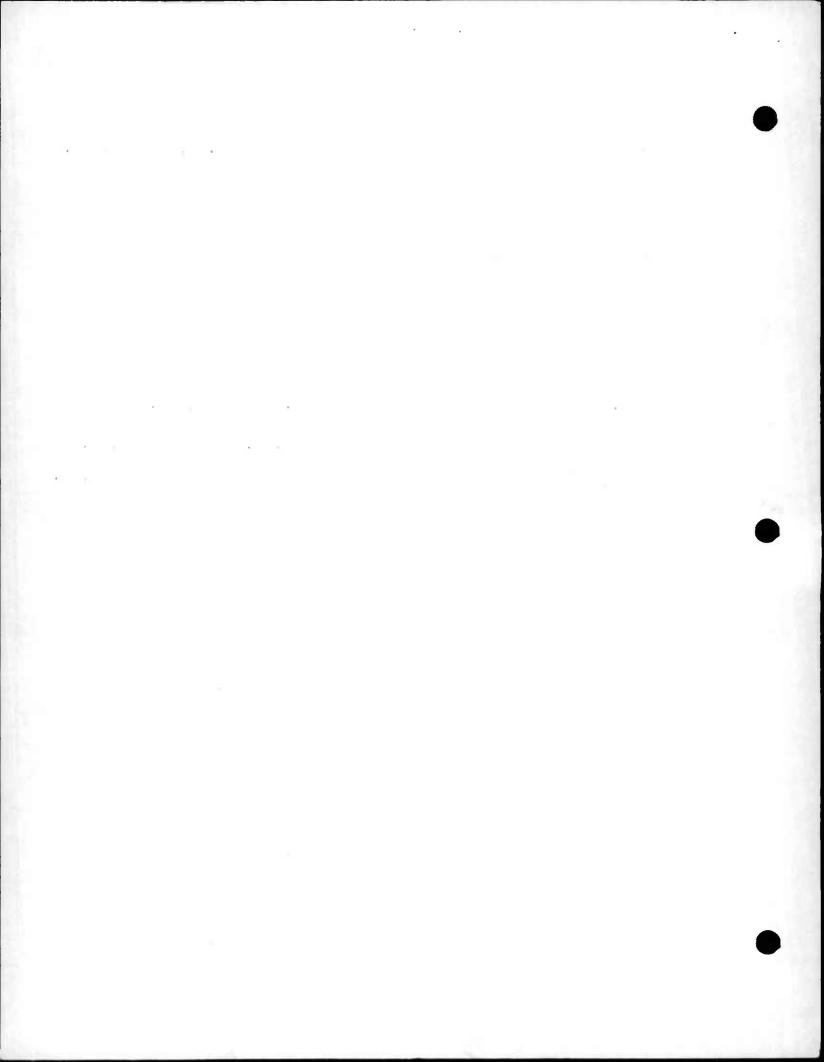
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	TMENT OF	HEALTH AND F DEATH) MENT	AL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)	,					TE OF OEATH	DAY Y	VEAR	IME OF DEATH			
	Dorothy Elizabe					A	DIII	0,199.	5 /	345P "			
	4. SOCIAL SECURITY NUMBER 177-24-7385	5. SEX 6. AGE (1	(In yrs. last birthday) 4 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DAT	TE OF BIRTH onth, Day, Year)	1930	Mary I	E (State or Foreign			
į	9a. FACILITY NAME (If not institution, give	21-	4	9h. CITY, TOWN	OR LOCATION OF		t. 40,		Y OF DEATH				
OR	Washington Cour				gerstown				ingtor				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		10c CITY	Y, TOWN OR LOCA									
S I	51515100	hington	agerstoi					77	INSIDE CITY LIMITS? YES 2 NO				
	10e. STREET AND NUMBER	voivg voi			IOI. ZIP CODE			10g. CITIZE	EN OF WHAT				
FUNERAL	1105 Salem Aver				2174				U.S.A.	•			
	11, MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, s	ECENDENT OF NISP	ican, Puerto	3IN? (Specify Ye to Rican, etc.)	es or No- 14	4. RACE — Ar Black, Whit	merican Indian, Ita, etc.			
5	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA			S 2 NO Spec				Specify:	hite			
3	15. DECEOENT'S EDU (Specify only highest grade	UCATION in completed)	USUAL OCCUPATI	ION	11	66. KINO OF BU	USINESS/INDUS		Nilve				
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	e retired.)				2.4	2					
	17. FATHER'S NAME (First, Middle, Last)	0	e Opera			lothin		factui	rer				
	Wesley Edwin Bi	i naaman					aret Mo						
H H	19a. INFORMANT'S NAME (Type/Print)	ingunan	19b. MAILING	AGORESS (Street	and Number or Rura				anda)				
2 ∥	Wilfred C. Jack	kson			venue H					1740			
	20a, METNOD OF DISPOSITION 1	20b.	PLACE AND DATE O	OF DISPOSITION (N	Name of	0.4	ATE 20c. LC	OCATION - CIE	ty or Town St	tete			
	4 Donation 5 Other (Specify)	Ced	netery, crematory or oth CAP LAWN										
ļ !	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home												
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
CERTIFICATION	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST List only one cause on each line. Interval Batwean Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
	PART II. Other significent condition	ns contributing to death be	ut not resulting in	n the underlyin	ng ceuse given i	in Part i.				E AUTOPSY FINDINGS			
							1 TYES		COMP	ABLE PRIOR TO PLETION OF CAUSE EATN?			
										YES 2 NO			
PH TSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES			IN 🗆							
2	EXAMINER?	HOSPITAL:		OTHER:	·								
	27. MANNER OF DEATH	28a. OATE OF INJURY	28b. TIME	OF 28c, IN.	me 5 Residence	_	her (Specify) ESCRIBE NOW	INJURY OCCUR	RED				
	1 Natural 5 Pending	(Month, Day, Year)	INJU	URY WO	YES 2 NO			mooni ooss.	TED				
	3 Suicide 8 Could not be	28s. PLACE OF INJURY	— At home, farm, st			28t. LC	OCATION (Street	and Number or	Rural Route N	Vumber,			
	4 Nomicide determined	annuigh are falter	·y)			Çiri)	ty or Town, State))					
		SICIAN: To the best of my knowle											
		ER: On the beats of exemination								manner as stated.			
1	295. SIGNATURE AND TITLE OF CENTURAL	c ///.	700	Α.	29c. LICENSE NO	UMBER		29d, DATE S	HOMED (Month	h; Dies: Mourt			
lk	7 yeller	VIV.	NIV	V. 2	023	65	23	1	110	135			
4	30 NAME AND ADDRESS OF PERSON WE	the KASS	TILL	Print)	799	Hu	well	Rel	Ifen	gestan			
	APR 1 2 199	32. REGISTRAR'S SIGNA	ATURE AND AND AND AND AND AND AND AND AND AND							19			

LANCE OF STREET

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physicia	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to	cremation or removal
DIVISION OF VITAL RECORDS, P.O. BOX (L DR ATTENDING PHYSICIAN: The law requires that the death certificate be exe	. DIRECTOR: After this certificate has been signed by the attending physician an	hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal

an. transit permit. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the TO THE FUNERAL DIRECTOR. After this certificate has been signed by 1 be filed within 72 hours after death with the State Dept. of Heary 39 is marked to team 33 shours and in FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)	Daught							2. DATE OF DEATH			3. TIME OF DEATH
	NANCY	JENKINS				APRIL 11, 1995			9:38A M			
	4. SOCIAL SECURITY NUMBER 224-38-9839	5. SEX 1 M 2 XF	6. AGE (In yrs. les 62		IF UNDER 1 Y		IF UNDER	MIN.	7. DATE OF BIRTH	1932	8. BIRTI Count	HPLACE (State or Foreign VA.
OR RO	9a. FACILITY NAME (If not institution, give start JOHNS HOPK		ITAL		96. CITY, TO BA			ON OF DE		9c. COU	NTY OF D	DEATH
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CITY	TOWN OR L	OCATIO	ON.					404 INDIOS OUTV
DIRECTOR	Maryland Wo	rcester			ocomo	oke						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	711 Short S					101,	ZIP COD	185	1	10g. CIT	USA	WHAT COUNTRY?
A	11. MARITAL STATUS 1 Never Married 2 Nerried 3 Widowed 4 Divorced	FORCES? 1	NT EVER IN U.S.AR I YES 2 AN MAR OR DATES	MED	H ye	s, spec		ın, Maxicai	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No—	Blac	E — American Indian, k, Whila, etc. My: Black
	15. DECEDENT'S EDUC (Specify only highest grade		16e. DE	CEDENT'S L	JSUAL OCCU	PATION	of works		16b. KIND OF BUS	SINESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	life.	omes	retired.)	ny most	UI WO'RII	9	Hous	ewif	e e	
m m	17. FATHER'S NAME (First, Middle, Last) Daniel Dat	ughtry		7.6					ME (First Middle, Meiden e Ely			
2	19a. INFORMANT'S NAME (Type/Print) Rev. Isaac	Jenkins	198	711	Sho1	reet and	St.	or Rural F	COMOKE,	Md .	218	51
T MUST	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo		20b. PLACE A carmetery, cra New	Mace	donia	a E	lapt	-	4-45-95 We	stov		
examiner must be	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Value Company Com										as Vat	
in the second	23. PART I. Enter the diseases, pro	omplications the	t caused the de	eth Do no								Approximata
event, the medical	shock, or heart feilura. I IMMEDIATE CAUSE (Finei disease or condition reaulting in death)	list only Dna cat	use on asch line						orcu, emb			interval Batween Onset and Death
	Sequentially list conditions, if any, leading to immediate		(OR AS A CONSEC		:							Years
TIFIC	CAUSE (Disease Dr Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEC	OUENCE OF)	:							
E E												
MEDICAL C	PART II. Other significant conditions	contributing to	death but not re	esulting in	tha undar	riying	cause (givan in i	Part I. 24s. WAS AN PERFOR	MEO?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
-	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YES	ПИС	म	UNC	FRTAIN	_			1 YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL				(Check only		-					
YSICI/	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3		OTHER:	Home	5 🗆 Re	sidence	8 Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D	INJURY Pay, Year)	26b. TIME INJU	OF 260	. INJUF	RY AT		28d. DESCRIBE HOW II	JURY OC	CURED	
	3 Suicide 8 Could not be determined	28a. PLACE O building,	F INJURY — Al hor etc. (Specify)	ne, ferm, sti	reel, factory,	offica			281. LOCATION (Street a City or Town, State)	nd Number	or Rural I	Route Number,
ZE I	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of	my knowledge, dea	ith occurred	at the time	deta a	nd place	and due	to the enuerich and man			
SE COMPLETED	298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									and manner as stated.		
TO BE	29b. SIGNATURE AND TITLE OF CENTIFIER		N			1	LG LGE	NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
-	M. WILLIAMS MD	COMPLETED CAUS		arm A	rine)	B	atti	mor,	MD 2120	25		
4	31. DATE FILED (Month, Day, Year) APR 14 1995	1.	A'S SIGNATURE	odata.					740			



DHMH-18 Rev 1/89

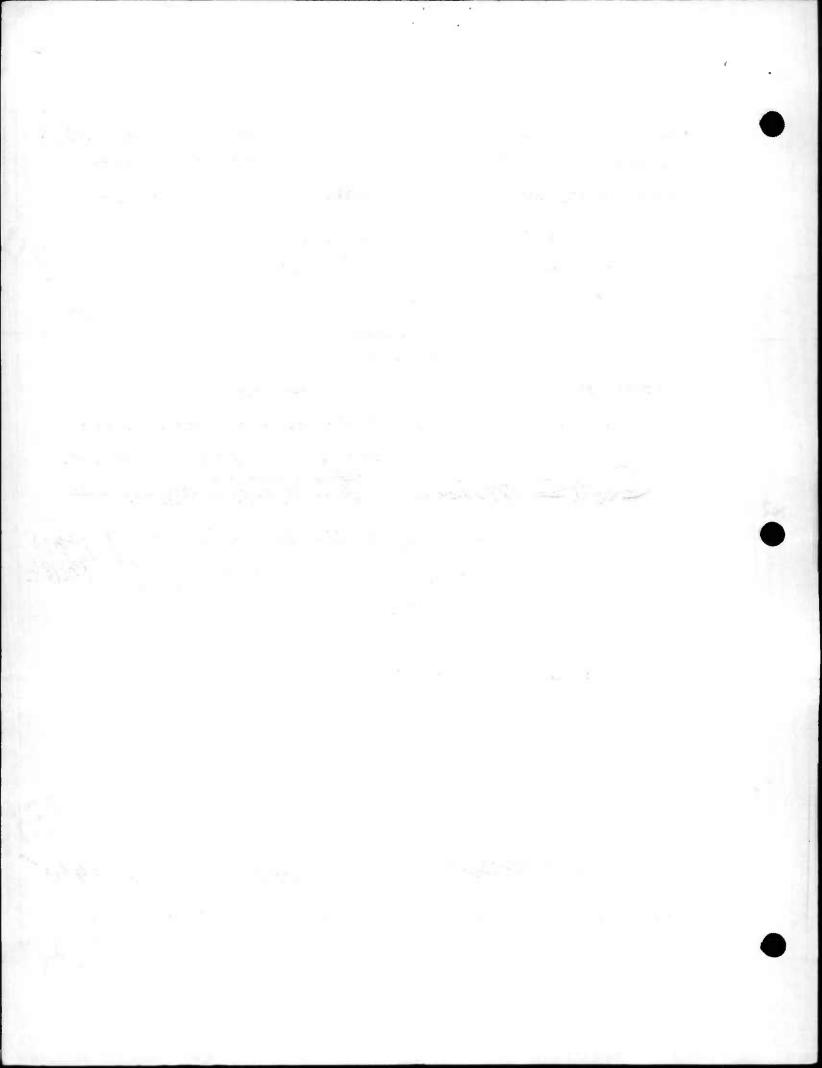
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

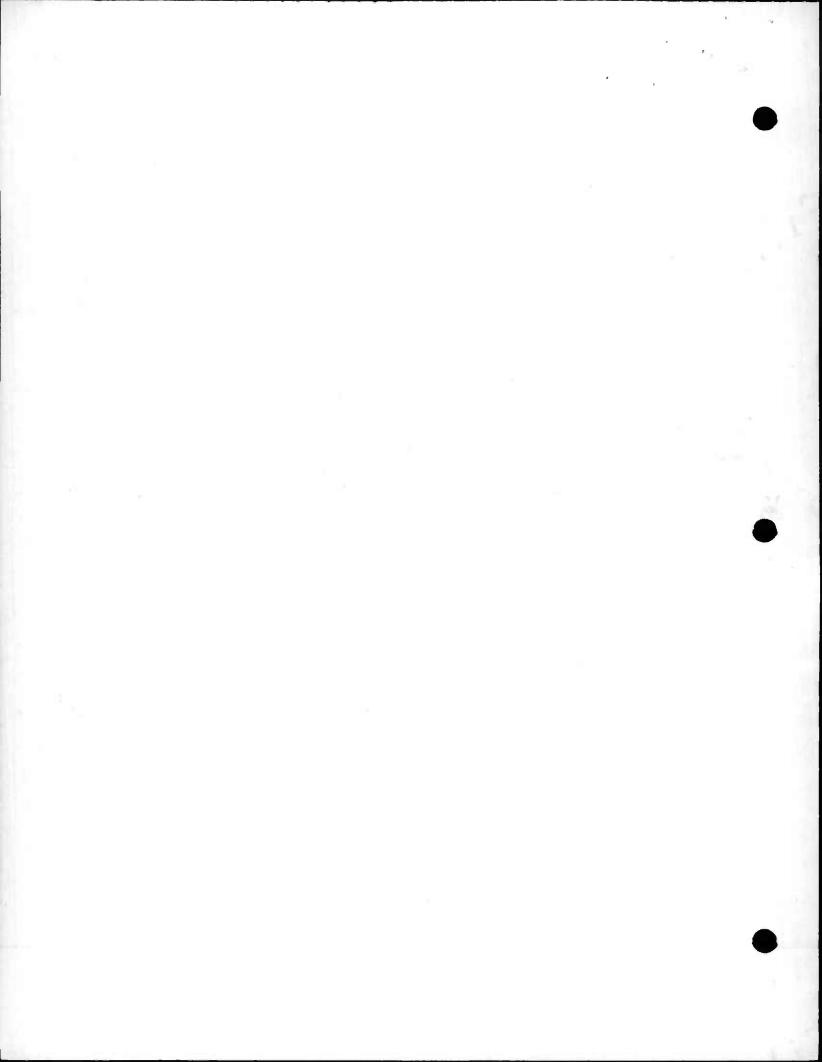
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	HAZEL JON	NES				APRIL O		1:35 P M		
	AND SHOULD BE SHOULD BE	SEX 6. AGE (In yrs. In		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Qay, Year)	8. BIRT Coun	HPLACE (State or Foreign		
	212-74-9819 1 9e. FACILITY NAME (If not institution, give street		89 YRS.			8/28/1905		yland		
Œ	Berlin Nursing Hom		- 1		R LOCATION OF DI	EATH	9c. COUNTY OF			
DIRECTOR	RESIDENCE OF DECEDENT	ie		Berlin			Worcest	er		
2	10e. STATE 10b. COUNTY		35 1	TOWN OR LOCATE	7,1			10d. INSIDE CITY LIMITS?		
	Maryland Worces	ter	Poco	moke Ci	ZIP CODE			1 - YES 2 X NO		
RA	4641 Stockton Road	1		100,00	04.074					
FUNERAL		. WAS DECEDENT EVER IN U.S. A	RMED		21851 USA DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian,					
BY F	1 Never Married 2 Nerried 3 Widowed 4 Divorced	FORCES? 1 YES 2 K	NO	It yes, spe	city Cuban, Mexica 2 NO Specif	n, Puerto Rican, etc.)	Blac Spe	ck, White, etc.		
								white		
15. DECEDENT'S COUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INOUSTRY										
립	Elementary/Secondary (0-12) C	college (t-4 or 5 +)	nemake	r						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
Denard Holland Annie W										
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
	Marion S. Jones					comoke Cit				
	1 X Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State cemetery, cri	ematory or othe	DISPOSITION (Nar r place)			CATION — City or T			
	21. SIGNATURE OF FUNERAL SERVICE LICENS		VIII C	emetery 22. NAME AN	O ADDRESS OF FA	4/11 Pocc	omoke Cit	v Md		
	South	mm.0.			n Funera					
	23. PART i. Enter the diseases, or com	plicetions that caused the d	eeth. Do not	PO Bo	x 64, Po	comoke Cit	y, Md.	21851		
	shock, or heert failure. List IMMEDIATE CAUSE (Finsi	only one cause on each line	e.					Interval Between Onset and Death		
	disesse or condition resulting in desth)	CONO	h n's	2 Do	Lenn	カディョ) e	1 Desirs		
	s	DUE TO (OR AS A CONSE	OUENCE OF):	/	, 1		v.1 /	7 60		
8	immediate cause (Final disease or condition resulting in desth) s. CONDANY DALENY DISTRIBUTIONS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
E	if sny, lesding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	QUENCE OF):	0						
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):	-						
CERTIFICATION	resulting in death) LAST							1		
	PART ii. Other significent conditions co	ontributing to death-but not	resulting in	the underlying	Ceuse alven in	Part I. 24a, WAS AN	ALITOPEY 241	. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICAL	ten MIT	in Par	2Um	ONIA	,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
₩ FD			-			1 YES 2	X NO	DF DEATH? 1 YES 2X NO		
ä								· L ies ·A ino		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:			ACE OF OEATH (Ch	eck only one)				
YSI	1 YES 2X NO	Inpatient 2 ER/Outpatient	DOA 4		5 🗆 Residence	6 Other (Specify)				
표	27. MANNER OF DEATH 1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WOR	RK?	28d. DEŞCRIBE HOW II	NJURY OCCURED			
B≺	2 Accident Investigation	28s. PLACE OF INJURY — At he	ome form stre		ES 2 NO	28I. LOCATION (Street a	and Alumbay as Ound	On the Humber		
8	4 Homicide 8 Could not be determined	building, etc. (Specify)		ret, rectory, office		City or Town, State)	no number or numer	Proute Number,		
'n	290. CERTIFIER 1 X CERTIFYING PHYSICIAN	t: To the best of my knowledge, do	anth occurred	et the time date of	and place and due	4. db - 2				
COMPLETED		n the basis of examination end/or						s) end manner es stated.		
ECC	29b. SIGNATURE AND TITLE OF CERTIFIER	70.0			29c. LICENSE NUN			O (Month, Day, Year)		
ω	70				D02026		Mani	1961		
5	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH (ITE	M 27) (Type, Pr	int)	_ 3_3_0		- 1/1-00			
10	FEDERICO G. ARTHES,		EAN PI	NES BE	RLIN, M	D. 21811	410-641-	6363		
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE			-					
	APR 1 3 1995	Fire.								



BALTIMORE, MARYLAND 21215-0	res that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending
MARYLA	retained by the
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	e death certificate be executed within 24 ho
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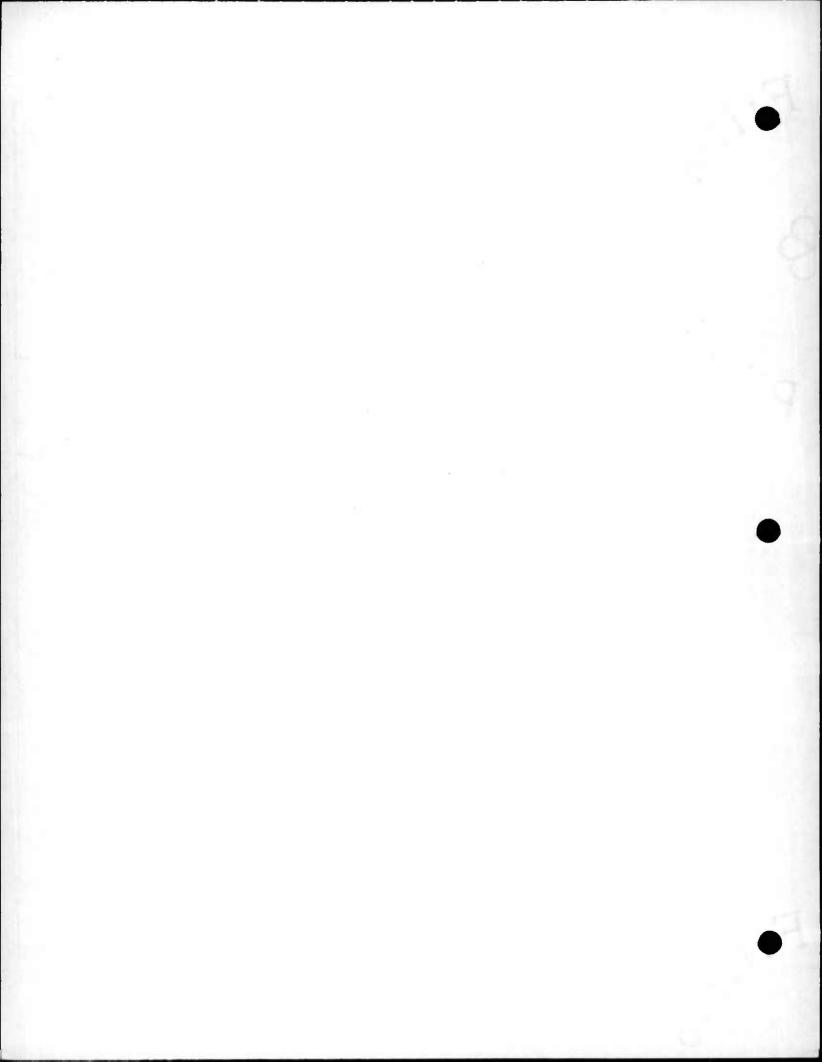
		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	EALTH AND	MENTAL HYGI						
	-	1. OECEDENT'S NAME (First, Middle, Last)	Ter 1. 1. 100				2. DATE OF DEAT		YEAR 3. TIME (OF DEATH			
	1		JENKINS				04	28		:30 PM			
		4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yes		8. BIRTHPLACE (St Country)	tate or Foreign			
Pin		225-28-5030 9e. FACILITY NAME (If not institution, give si	1 M 2 X F 79	YRS.			Aug. 15.	1915	Virgini	a			
. 2, 3 should	DIRECTOR	Reeders Memorial			Boonsbo	OR LOCATION OF O	EATH	100	TY OF DEATH				
Pages 1	EC.	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION			10d. INS	IDE CITY			
permit. Pa		Maryland Wash	ington	E	Boonsboro					S 2 NO			
isit pe	FUNERAL	143 S. Main St.			100	I. ZIP CODE			EN OF WHAT COU	NTRY?			
020 physician. bunal-transit	S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMEO			NIC ORIGIN? (Specif	Yas or No-	S.A. 14. RACE — Americ	can Indian,			
	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO		ecify Cuban, Maxica 2 NO Specia	en, Puerto Ricen, etc. fy)	Black, White, at Specify:	tc.			
- 6 70		15. DECEDENT'S EDUC	CATION	40- DECEDENTIA	1					ite			
	ETE	(Specify only highest grade	completed)		USUAL OCCUPATION Work done during mose retired.)		16b. KIND OF	BUSINESS/INOL	JSTRY				
ND 2 hospital of ached for	P	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Home	maker		Our	Uomo					
	COMPL	17. FATHER'S NAME (First, Middle, Last)		ПОШС		18. MOTHER'S NA	ME (First, Middle, Ma	HOME Iden Surname)					
1 6 6 6 A	BE C	Richard Edwin Jol	liffe			Pea	arl Settl	e					
MAR retained 5 should notified	10	19a. INFORMANT'S NAME (Type/Print)	DAILY ST. LEW LOND OF THE ST. LEWIS CO., LAND OF THE ST. LEWIS CO., LAND OF THE ST. LEWIS CO., LAND OF THE ST.	19b. MAILING	ADDRESS (Street a		Route Number, City or		Code)				
	-	Ray Jenkins					erdstown.	WV 25	5443				
		20s. METHOD OF DISPOSITION 1 VBurisi 2 Cremation 3 Remo	rval from State cem	etery, crematory or o					Olty or Town, Stata				
- 0 0 -		4 Donation 5 Other (Specify)	ENSEE	Hillcres	t Memory	Gardens	S 5/2/95	Jeffer	sonton				
a ath		16.1					Funeral	Home					
- E 10	_	Liall (850 S	Sperryvi	lle Pike	Culper	er Va	22701			
W 3	- 1	23. PART i. Enter the diseeses, or c ehock, or heart feliure. I	omplications that caused list only one cause on ea	the deeth. Do i och line.	not enter the mo	de of dying, suc	ch aa cerdiec or r	eapiratory erre		proximate erval Between			
1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		iMMEDIATE CAUSE (Finei disesse or condition	Mestera	Ldi's	1 %	lone	for		One	set and Death			
ted within 24 completely fille ial, cremation, event, the		resulting in deeth)	DUE TO JOH AS A	CONSEQUENCE O	FIE 12	Tovo 9	tion Disea		20	nice			
19 P P P P	2	-	Coson	aru	are	cry o	rised	2e ·	18	mlle			
	2	Sequentielly list conditions, if any, leeding to immediate											
cate be thysicial prior trace	RTIFICATIO	cause. Enter UNDERLYING CAUSE (Disease or injury that injury that injury that injury that injury to the injury that injury tha											
certifical ding phy Hygiene	Ë	thet initiated events resulting in deeth) LAST	(DUE TO (OH AS A	CONSEQUENCE OF	f(c)				1				
T E 9 - 0	CE		-										
하는 하는 하는 다른	님	PART ii. Other significant conditions			in the underlying	g ceuee given in	Part i. 24e. WAS	AN AUTOPSY FORMED?		TOPSY FINDINGS E PRIOR TO			
uires that the signed by the Hearth and bows any in	EDIC	- Selli a	2. km		9			S 2 NO		ION OF CAUSE			
w requires been sign or, of Heaf	2	18887		reuni						2 NO			
The law requires that the has been signed be are Dept. of Health and the are 23 shows any	ž	DID TOBACCO USE CONTR				UNCERTAI	N 🗆						
N: The ficate h State [PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YOUNG	HOSPITAL:		TH (Check only one) OTHER:								
the the	H	27. MANNER OF DEATH	t ☐ Inpetient 2 ☐ ER/Output 28e. DATE OF INJURY	28b. TIM			8 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCI	IREO				
NG PHYS fter this cath with		1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK? res 2 No							
OR ATTENDING DIRECTOR: After hours after death Item 28 is mai	D BY	2 Accident Investigation 3 Suicida 8 Could not be	28s. PLACE OF INJURY building, stc. (Speci	— At home, farm,	street, factory, office		28f. LOCATION (Str	eet and Number o	or Rural Route Numb	>er,			
ATTEN ECTOR: S after		4 Homicide determined	banding, are. (Opeci				City or Town, S	rate)					
	COMPLETE	29a. CERTIFIER 1 CERTIFYING PHYSIC	EAN: To the best of my knowle	adge, daath occurre	ed at the time, date	and place, and due	to the cause(a) and	manner as states	d.				
THE HOSPITAL THE FUNERAL filed within 72 I	O.		: On the beels of examination							ner as stated.			
TE FU TE FU Sed with	w II	29b. SIGNATURE AND TITLE OF CERTIFIER	-V			29c. LICENSE NUI	MBER 1	29d. OATE	SIGNED (Month, De	sy, Year)			
TO THE HOSPITA TO THE FUNERA DE filed within 7. IMPORTANT: I	10 B	Miller		m. J		D45	031	DA1	129 95				
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DEA		Print)								
**************************************		31. DATE FILED (Month, Day Mari	1 . 32 REGISTRAN'S STENA		VVV								
		MAY 05 1995	LA STREGISTRAD'S STENA	tall									



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LA	and the
MAR	a bonings
BALTIMORE, MARYLAND 21215-0020	O 24 hours offer death Dane & rows he essented by the bearing as the first
BALT	offer death
_	house
	7.0

FOR STATE REGISTRA	AR		STATE OF MARYL	AND / DEPARTMENT CERTIFICATE	MENTAL	HYGIENE REG. NO.
1. DECEDENT'S P	Myung	S.	Kim		2. DATE O	DAY

		4 DECEDENTIA NAME (5:										1120.110			
		1. DECEDENT'S NAME (First Mary Myu		. Kim	ı						2. DATE	of Death	100	YEAR	3. TIME OF DEATH 2:00 PM
		4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs.	Inst history	IF UNDER	4 MEAR	T m inner				1993		
		219-35-72		1 M 2 X F	43	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	of BIRTN th, Day, Year) 16, 1	051	Country	
3 should	1	90. FACILITY NAME (If not in	etitution, give e	treet and number)	101		96, CITY	. TOWN	OR LOCATI	ON OF DE	_	10, 1		Kore	
	S.	11632 Lock	wood D	rive, Ap	t. 104				Spr				Mont		
1, 2,	5	RESIDENCE OF DEC						-					HOLLE	gome	Ly
Pages	DIRECTOR	Money I am d	10b. COUNTY			10c. CITY, TOWN OR LOCATION Silver Spring									10d. INSIDE CITY LIMITS?
регшії.		Maryland 100. STREET AND NUMBER	Montg	omery		Sil	Lver								1 YES 2 NO
	ERAL	11632 Lockw	ood Dr	ivo Ant	110%			10	f. ZIP COD				1.1		HAT COUNTRY?
020 physician. burial-transit	FUNE	11. MARITAL STATUS	OOU DI	12. WAS DECEDEN		ARMED	13	WAS DEC	2090		MIC ORIGI	N? (Specify Yes		orea	American to the
215-0020 attending physician. se as the burial-trar	1	1 Never Merried 2 🔀		FORCES?	I ☐ YES 2 ₽	ON		if yes, sp	ecify Cube	en, Mexica	ın, Puerto	Rican, etc.)	01.10-	Black, Specifi	- American Indian, White, atc.
ending as the	р ву	3 Widowed 4 Divo		**********					- 63						rean
	ETED	(Specify only	EDENT'S EDU highest grade	CATION completed)		Give kind of	work done	CCUPATIO	ON ost of working	ng	188	. KIND OF BUS	INESS/INO	USTRY	
D 2 pital o		Elementary/Secondary (0	-12)	College (1-4 or 5	+)	Homen	1100					Own H	1 am a		
the hospital detached for	COMPL	17. FATNER'S NAME (First, M.	iddle, Last)			Homen	lakei		18 MOT	HEB'S NA	ME (Elm)	Middle, Maiden			
\$ & & Z	i m	Park Yong J:	in							Kook		middie, Maideri	Surriame)		
MAR retained 5 should	O BE	19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRESS	(Street	and Number	r or Rural I	Route Num	ber, City or Town	n, State, Zip	Code)	20904
2 2 40 2		Kyung Kim													Spring, MD
BALTIMORE, hours after death, Page 6 may be ed in by the funeral director, page or removal.		20a. METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	20b. PLAC	E AND DATE	OF DISPOS	ITION (No	ame of	,	OAT	E 20c. LO	CATION (City or Tow	rn, State
MOF age 6 m director,		4 Donatton 5 Other		chocc	Gate	of H	eaver	ı Ce	mete	ry 4	-19-	95 Silv	er S	pring	g, Maryland
ALTIMOR death, Page 6 ma tuneral director, p		1	1. 1	1 a A	1/20	1	Vi	1800	New	ss of fa	nnshi	nes-kı re Ave	nata:	1 Fur	neral Home
BA the fee of the fee	1 1	Kime	Ch	and 1	Tall	anc	K S	ilve	er Sp	ring	g, Ma	ryland	209		
bours after of in by the or removal.		23. PART f. Enter the di ehock, or he	seasea, or c	complications the List only one cau	t caused the use on each ill	daeth, Doi	not enter	the mo	de of dy	ing, suci	h ea cen	diec or respi	ratory arm	est,	Approximata interval Between
24 lon,		IMMEDIATE CAUSE (Fin	el	1 Rt	1										Onset and Death
ted within 24 completely fill, cremation, the		resulting in death)	→ ,	o. U/OZ	COR AS A CONS	CQ	nce								
B 6 . 8				DUE TO DUE TO DUE TO DUE TO	es fort	- 0	0	11 M	01	Ω		Prince			
0 5 5	ERTIFICATION	Sequentially list conditi if any, leading to immed	ona, diate	DUE 10	(OR AS A CONS	EOUENCE O	F):	110		0		4/6/3			
cate by hysicia	<u>ŏ</u>	ceuse. Enter UNDERLY! CAUSE (Disease or Inju	NG Y	1100	CONC	C	1	Cel	1/	3	om	2			
death certificate attending physic ental Hygiene pri		that initiated events resulting in death) LAS	r	DUE 10	(OR AS A CONS	EQUENCE O	F):								
death attend	Ü			J											
of the C	AL.	PART II. Other significal	nt condition	s contributing to	deeth but not	resulting	in the un	derlying	g ceuse g	given in	Part I.	24a, WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
uires tha signed ! Health a	MEDICAL										_	1 YES 2	. 1		COMPLETION OF CAUSE OF DEATH?
requires been sign of Heal									,		_ !			- 1	1 - YES 2 - NO
AL KE he law requ has been be Dept, of P	AN	DID TOBACCO US		RIBUTE TO CA					UNC	ERTAIN	N 🗆				
SICIAN: The certificate h the State (SICIAN:	EXAMINER?	MEDICAL	HOSPITAL:	-7-	ACE OF DEA	OTHER		V						
SICIAI Certific] ≽ []	27. MANNER OF OEATH		1 Inpatient 2 I	INJURY	28b. TIM	4 - Nun	ing Hom 28c. INJ		eldence	6 Othe	r (Specify)	IIIIIV OCC	UDED	
F SE SE SE	ВУ Р	/_ \	Pending nvestigation	(Month, D	lay, Year)	INJ	JURY M	WO	RK?	NO	200. 023	CRIBE NOW IF	JUHT OCC	UHED	
NDING NDING R. After or death		3 Sulcide 8 G	Could not be	28e. PLACE O	F INJURY — At I	nome, farm,	street, facto	ory, office	•	7.7	28f. LOC	ATION (Street a	nd Number	or Rural Ro	ute Number,
DIRECTOR: After bours after death		4 Nomicide	letermined		etc. (opecity)						City	or Town, Stete)			
	12	290. CERTIFIER (Check only	FYING PNYSIC	CIAN: To the best of	my knowledge,	seath occum	ed at the ti	me, dete	end place,	end due	to the cau	se(e) end men	ner es state	d,	
TO THE HOSPITAL TO THE FUNERAL Se filed within 72 ?	O.														and menner ea stated.
HE HE HE RE RE RE RE RE RE RE RE RE RE RE RE RE	BE	296. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	NSE NUM	ABER		29d. DATE	SIGNED (Month, Day, Year)
TO THE HOSPIT TO THE FUNER be filed within	0	1121	ME	7					D/9	190	5		Ap	ril	17, 1995
)	-	30. NAME AND ADDRESS OF Dr. Year	-Kwon	Yoon,	SE OF OEATH (IT	EM 27) (Туре, О 7 Ва	Print) 1time	ore	Ave.	. Co	1100	e Park	. MD	207	40
1		31. DATE FILEO (Month, Day,)								, 00		Luik	, 111/	207	70
		APR 21 19	395 8	32. TEGISTINA	מירושויום	4]



		FOR 1 - STATE REGISTRAR	STATE OF N				HEALTH A		NTAL HYGIEN) 1	10702
		1. DECEDENT'S NAME (First, Middle, Last)				10/112	DEATT	2.	DATE OF DEATH		3.	TIME OF DEATH
		DONALD AL	LEN X	AYSE	R .				MONTH D		EAR	7.13 PM
		4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.		IF UNDER 1 YEA			DATE OF BIRTH (Month, Day, Year)	0.		ACE (State or Foreign
모			1 1 2 F	45	YRS.	MONTHS DAY	S HOURS	MIN.	JANO7 5	0	Mary Mary	yland
pinous	~	9a. FACILITY NAME (If not institution, give str					N OR LOCATION			9c. COUNTY		· ·
2, 3	стов	WASHINGTON C	o HOSFI	TAZ.		HATGI	PSTON	07/	MD -	WAR	SHIN	G707)
Jes 1,	E C	10a. STATE 10b. COUNTY			10c. CI	TY, TOWN OR LO	CATION				10	d. INSIDE CITY
Ž.	DIRE	$m \mathcal{D} \cdot Wa$	shington			Hagers	town					LIMITS?
permit. Pages	AL A	10e. STREET AND NUMBER				nagere	10f. ZIP CODE			10g. CITIZEI		T COUNTRY?
sit	FUNERAL	920 Linwood Road				-	21740)		U.	S.A.	
020 physician burial-trai	5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	TEVER IN U.S.	ARMED		DECENDENT OF specify Cuban,		RIGIN? (Specify Yes		. RACE -	American Indian, /hile, etc.
ing ph	ΒY	1 Never Merried 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			ES 2 NO		erto Miceri, etc.)		Specify:	
215-0 attending se as the	ED	15. DECEDENT'S EDUC		Reserve		USUAL OCCUP	ATION		16b. KIND OF BU	SINCE OF CINETIES		White
2121	ᇤ	(Specify only highest grade of Elementery/Secondery (0-12)	completed) College (1-4 or 5+		(Give kind of life. Do NOT u	work done during	most of working		100. KIND OF BU	SINESS/INDUS	IHY	
AND 2. the hospital of detached for once.	릴	0-12	0	·	Sales	Associ	ate		Applia	nce		
the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			DUTES	ASSOC I		R'S NAME (/	First, Middle, Maiden			
d by d	ш	Rupert L. Kayser	.Jr.				Virg	ginia	Lee Alb	ert		
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.	TO B	19e. INFORMANT'S NAME (Type/Print)					et and Number or	Rural Route	Number, City or Tow	rn, State, Zip Co		
	-	Linda Kayser			1227	W. Ch	urch St	reet	Hagers	town,	Md.	21740
E - 201		20a, METHOD OF DISPOSITION 1 □ Burial 2 □ Cremation 3 □ Remo	val from State		CEAND DATE	OF DISPOSITION	(Name of	1	DATE 20c. LO	CATION - City	or Town,	State
		4 ☐ Donation → 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGIT	NAME OF THE OWNER.			Crema						Maryland
ALTIN death. Pag funeral dis f. examiner		21. SIGNATURE OF TURESTAL SERVICE EL	mm				AND ADDRESS		ETHILC			
		- Scott O'	1000	nn	u				_			d. 21740
K = 2		23. PART I. Enter the diseeses, Dr co shock, or heart failure. L	omplications that ist only one caus	ceusad tha	death. Do i	not antar tha	mode of dying	g, such ss	cerdiec or respi	iratory arrest	l,	Approximate Interval Between
filled on or a		IMMEDIATE CAUSE (Final						1	4			Oneat and Death
ettely emati		disease or condition resulting in death)		COY	ONA	1-1	ocu	-105	1001			KIN
ted within complete ial, crem: event,			DUE TO	(OR AS A CONS	SEOUENCE O	F): /	000					
execute and c o buria	CATION	Sequentielly list conditions,		OR AS A CONS			2000					
Sician Sician trau	AT	if sny, leading to immediate cause. Enter UNDERLYING				• ••						
ertifical ng phy giene p	RTIFIC	CAUSE (Disease or injury that initieted events	DUE TO	OR AS A CONS	SEOUENCE O	F):						
J. H. Dug.	E	resulting in death) LAST										
. a = 3	L CE	PART II. Other aignificent conditions	contributing to	death but no	t resuiting	In the underh	ring cause gly	en in Part	i. 24a. WAS AN	AltTOREY	Tash WE	THE MITTOREY ENGINEE
- > 0 -	CAL					The discern	ing couse giv	en in Fait	PERFOR	MED?	AM	THE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION DF CAUSE
T. 'S "T PI	MEDIC								1 🗌 YES 2	NO	DF	DEATH?
WEC v requires been sign ft. of Heal	2	DID TOBACCO USE CONTR	IBUTE TO CAL	USE OF DE	ΔTH YI	ON PE	☐ UNCE	RTAIN [٦	ť	1 [YES 2 NO
AL he law be be bept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				TH (Check only o		KIAII1 L				
SICIAN: The Certificate he the State he the State he the State he the state he the	Sic		HOSPITAL: 1 Inpatient 2	ER/Outpetient	3 DOA	OTHER:	ome 5 🗆 Rasid	dence 6 🗆	Other (Specify)			
HYSICIA this certif with the	Ě	27. MANNER OF DEATH	26e. DATE OF (Month, Da		26b. TIM		INJURY AT WORK?	_	. DESCRIBE HOW II	NJURY OCCUR	ED	
DING PHYS After this death with	ВУ	1 Natural 5 Pending 2 Accident Investigation		y, 10m/y	1		YES 2 N	NO				
ATTENDING PHYSICIAN: The ECTOR: After this certificate has after death with the State D 28 Is marked, or Item 3	ED	3 Suicide 6 Could not be 4 Homicide delermined	26e. PLACE Of building, of	F INJURY — Al I	home, farm,	street, fectory, o	fica	261.	LOCATION (Street a	and Number or	Rural Route	Number,
OR ATTENDING DIRECTOR: After nours after deatt tem 28 is ma	10 H	4 Homicide determined										
	COMPLI	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC										
HOSPITAL FUNERAL within 72	Š	one) 2 MEDICAL EXAMINER	On the basis of ex	amination end/o	or investigation	on, in my opinio	, death occured	at the time,	data end place, en	d due lo lhe c	euse(e) en	d manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	w II	296. SIGNATURE AND TITLE OF CERTIFIER	0				29c. LICENS	SE NUMBER		29d. DATE SI	GNED (Mo	onth, Day, Year)
TO THE HOSPIT TO THE FUNERA be filed within 7	TO B	Music	w				DI	126	, 6	> Apri	1/3	95
		30. HAME AND ADDRESS OF PERSON WHO		E OF DEATH (IT		A	4		L	, 1		
		31. DATE FILED (Month, Day, Year)	-	1801		on the	1149	ers/	suc. 1	214		
		APR: 1 2 1995	-	'S SIGNATURE	21.11							
		AFR: 1 2 1999	June	AND THE PERSON NAMED IN	- Property							

and the same of

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and ours after death. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

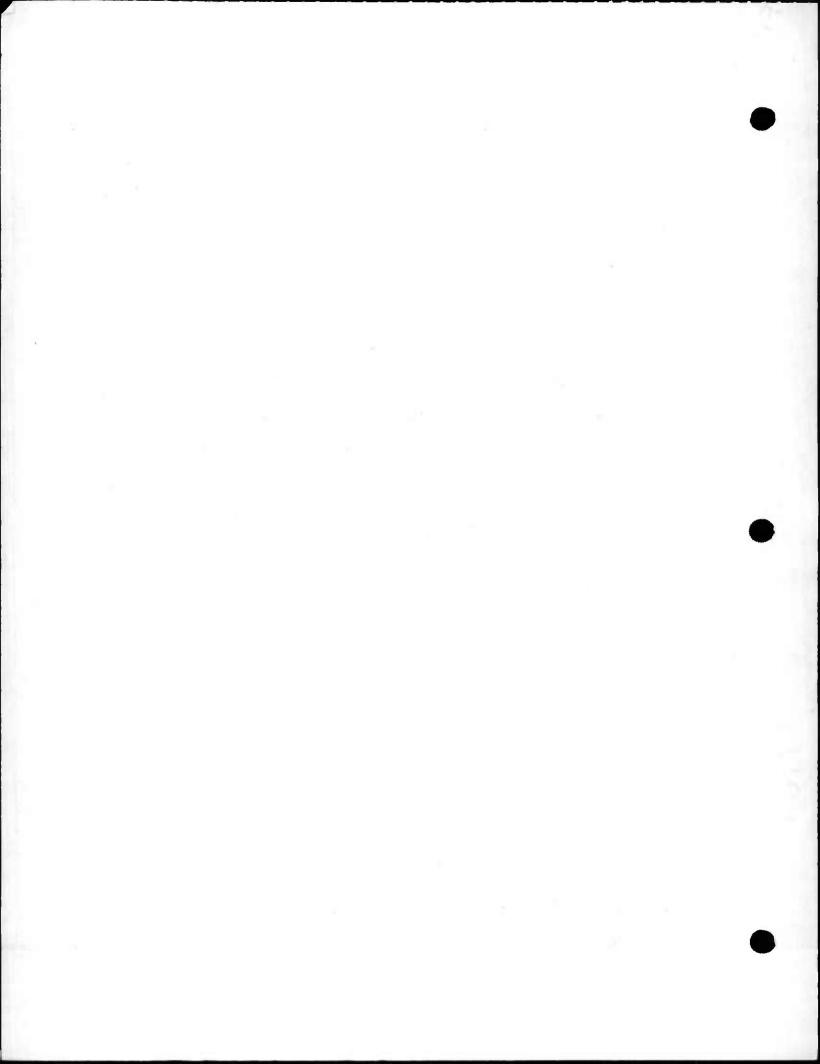
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR

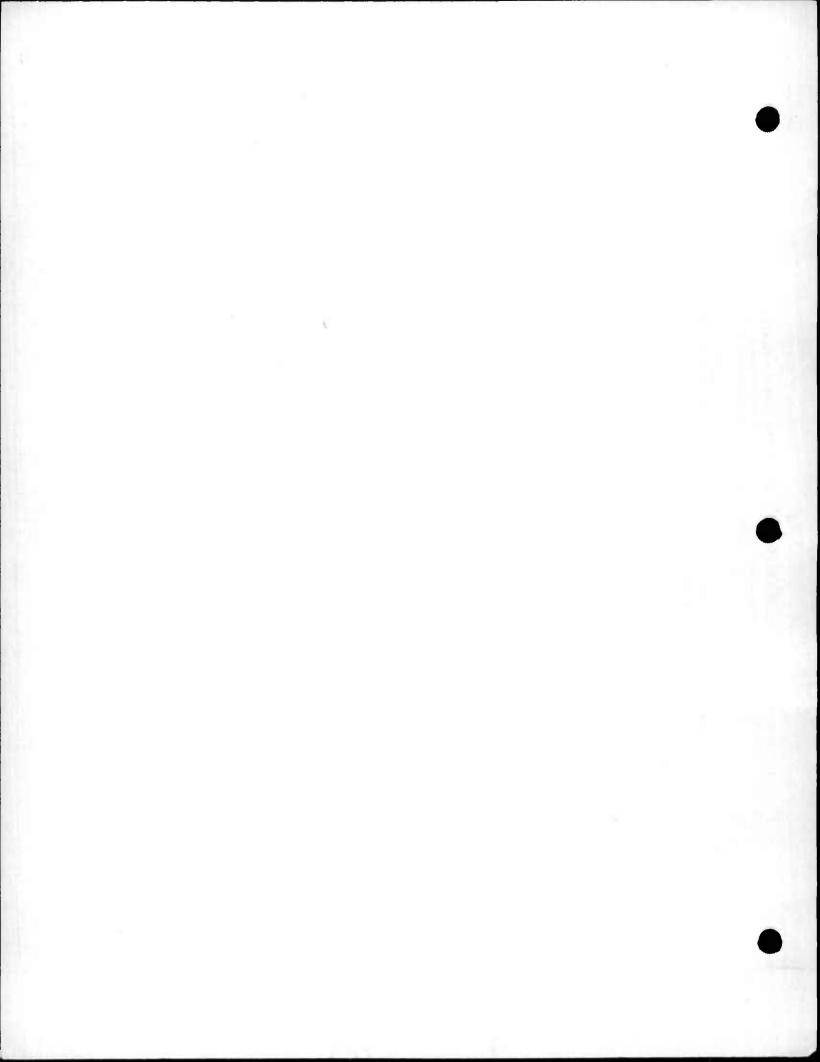
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - STATE REGISTRAR	OTTILE OF MARIE	CERT	FICATE	E OF	DEAT	H	MENIAL	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF MONTH	DEATH	W.	YEAR	3. TIME OF DEATH	
	LAWRENCE E.							APRII			TEAN	10:17 am M	
	Committee of the Commit		E (In yrs. lest birthde	MONTHS	DAYS	HOURS	24 HRS.	7. DATE OF (Month, D	lay, Year)		Country		
	228-24-4742 1 9s. FACILITY NAME (If not institution, give street		57 YRS		TOWN O	OR LOCATIO		JULY	3 19			INIA	
Œ.	ANNE ARHNDEL MEDIC					-	N OF DE	ATH			INTY OF DE		
5	RESIDENCE OF DECEDENT	AL CENTER		_ AI	NNAP	<u>OLIS</u>				ANN.	E ARU	INDEL	
DIRECTOR	10a. STATE 10b. COUNTY			CITY, TOWN C		ION				10d. INSIDE CITY LIMITS?			
	MARYLAND ANNE 100. STREET AND NUMBER	ARUNDEL	A	NNAPOI		710 0000					M∑ YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	909 COACHWAY					. ZIP CODE 21401						HAT COUNTRY?	
S	11. MARITAL STATUS 12	2. WAS DECEDENT EVER FORCES? 1 V YE	IN U.S. ARMED	13.	WAS DEC	ENDENT OF	F HISPAN	IIC ORIGIN? (Specify Yes	US.	14. BACE	- American Indian,	
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	DATES	NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify:						Specif	White, atc.			
	15. DECEDENT'S EDUCATI	16a. DECEDENT	r'e Heuar Da	CCLIBATIO	NA.	_	1 405 441	ND OF BUS		BLA	CK		
E	(Specify only highest grade con	(Give kind	of work done (use retired.)	during mos	st of working	7							
MPL		College (1-4 or 5+) 6+	PRINC	IPAL				A.A		. BO	ARD O	F EDUCATION	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTH	ER'S NA	ME (First, Midd	tle, Maiden	Surname)			
BE	LAURENCE E. KNIGHT 190. INFORMANT'S NAME (Typo/Print)					OCT	AVI	A WEST					
2	DORIS S. KNIGHT							Number, MD.			code)		
1	20e. METHOD OF DISPOSITION	2	0b. PLACE AND DAT				OLL	DATE			City or Tov	on State	
	1 N Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	I from State Co	ARYLAND	other plece)			FDV						
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22.	NAME AN	ID ADDRES	S OF FA	CILITY					
	Lavy & Re	Pal		RE	EESE 1 WI	& SO EST S	NS N	MORTUA ANNAPO	RY,]	P.A.	21/10	1	
	23. PART I. Enter the siseasea, or com	plications that caus	ed the death. Di	npt enter	the mod	de of dyir	ng, suci	as cardiac	Dr respi	ratory sn	rest,	Approximate	
	anock, or nesrt isliure. List	t Dnly one cause on	each line.									Interval Between Onaet and Death	
	disesse or condition resulting in death)	Venti	est t	16001	ATTE	n						1 kr	
	Sequentially list conditions, MMEDIATE CAUSE (Fins) Consett and Death Consett												
ON I	Sequentially list conditions, if sny, leading to immediate b. Type for the consequence of:												
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury												
E	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):									
CERTIFICATION	d												
AL O	PART II. Other significant conditions co	ontributing to desth	but not resultin	g in the un	derlying	csuse gi	ven in	Psrt 1. 24	a. WAS AN			WERE AUTOPSY FINDINGS	
DICAL								1	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
M								_	1			1 TES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTRIB	UTE TO CAUSE				UNCE	RTAIN	10					
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11	OSPITAL:	26. PLACE OF DE	OTHER	1 :								
HYS	27. MANNER OF DEATH	☐ Inpatient 2/2 ER/Ou 28a. DATE OF INJURY		4 Num	28c. INJU		Idence	6 Other (S)		LILIBY OC	CUBED		
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)		NJURY M	WOR	RK?	NO	200. DESCHI	BE NOW IF	SORT OC	COMED		
and the same	3 Suicide 8 Could not be	28a. PLACE OF INJUR building, atc. (Sp	IY At home, farn	, atreet, facto	ory, offica			281. LOCATIO	N (Street a	nd Number	or Rural Ro	oute Number,	
	4 Homicide datermined	,,						City of it	own, State)				
COMPLETED	29a. CERTIFIER (Check only one)												
Į	2 MEDICAL EXAMINER: 0	in the basis of examinati	on and/or investige	tion, in my o	pinion, de	with occure	d at the	time, data and	l placa, and	due to th	na cause(s)	and manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Om	2			29c. LICEN				29d. DAT	E SIGNED	Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF	EATH STEW	no Order		NOU	228			_	2/12	/25	
					21/	0.1							
	DR. BIERN 900 BESTO	32. REGISTRAR'S SIG	NATURE	, MD.	214	OT							
	ADR 1 8 1995	Janden K	artalle.]	



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1.0		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIE				
		1. DECEDENT'S NAME (First, Middle, Last) Betty Marie Whi	te Kalvinsky				2. DATE OF DEATH MONTH 17,	,° 1995	3. TIME OF DEATH 6:10 A M		
2		4. SOCIAL SECURITY NUMBER 216-30-0197	1 🗆 M 2 🙀 F	yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) November		BIRTHPLACE (State or Foreign Country) 5 Elkton, MD		
2, 3 should	стов	99. FACILITY NAME (It not institution, give st Laurelwood Nursi			96. CITY, TOWN Elkton	OF DEATH					
permit. Pages 1,	DIREC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Ce	cil		th East	ATION		10d. INSIDE LIMITS' 1X_ YES			
2	FUNERAL	100. STREET AND NUMBER 23 North Main Str	eet		-10	21901		10g. CITIZEN OF WHAT COUNTRY? USA			
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 ☐ YES IF YES, GIVE WAR OR DAT	2 X NO	If yes, s	CENDENT OF HISPAI pecify Cuban, Mexico S 2 1 NO Specif	NIC ORIGIN? (Specify on, Puerto Ricen, etc.) fy:	y Yes or No 14. RACE — American Indian, Black, White, etc. Specify. White			
AND 21215 the hospital or attend detached for use as once.	LETED	15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Give kind of a life. Do NOT us		ION lost of working		BUSINESS/INDUS	TRY		
AND The hospi detached once.	COMPLET	1.2 17. FATHER'S NAME (First, Middle, Last)		Bookke	eper	Le MOTUENIO MA		Manufac	turer		
YLA by the by the det	m l	Berchell Wilme:	r White		te. MOTHER'S NAME (First, Middle, Meiden Surmeme) Edna Marie Clayton						
MAR retained 5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)		4		end Number or Rural	Route Number, City or T	own, State, Zip Co	ode)		
		Sharon C. Walla	200 5		ittle Eg		Elkton,		921		
		20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ramo 4 Donetion 6 Other (Specify)	ovel from State comet	ery, crematory or o			1	Location - chy Charlest	or Town, State		
SALT r death. re funera al. exami		21. SIGNATURE OF FUNERAL SERVICE LIC	Civies	/	Croud	th Funera Main S	1 Home	East,			
ed within 24 hours a completely filled in by all, cremation, or remement, the medic	Z	23. PART i. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or haart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions									
th certificate be anding physician Hygiene prior to or other traus	CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):									
Signed by the Health and M	MEDICAL	PART II. Other aignificant conditions	e contributing to death but	not resulting i	in the underlyin	ig ceuse given in		AN AUTOPSY ORMED? 2 M NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
law rectast been of bept. of 23 sh	PHYSICIAN: N	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26		TH (Check only one)		ND		1 TYES 2 NO		
SICIAN: The Certificate the State	IYSI	1 TYES 2 NO NO	HOSPITAL: 1 Inpetient 2 ER/Outpeti			ne 5 🗆 Rasidenca					
ATTENDING PHYSICIAN: The CTOR: After this certificate his after death with the State C 28 is marked, or Nem	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW				
OR ATTENC DIRECTOR: hours after item 28 is	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	irrest, ractory, omo		26f. LOCATION (Stree City or Town, Stet	t end Number or F e)	Rural Route Number,		
東京な	COMPLETED		EIAN: To the beat of my knowled t: On the basis of exemination e						euse(e) end manner ae stated.		
TO THE HOSPI TO THE FUNEF De filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	ayerde	~.		29c, LICENSE NUM	MBER D75	29d. DATE SI	IGNED (Month, Day, Year)		
		322 E. Cec	COMPLETED CAUSE OF DEAT	ue 1	1.	no a	1901				
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	all							



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BALTIMORE, MARYLAND 21215-0020	10 24 hours after death Pane 6 may be retained by the hospital or attending placing
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MAR	retained
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ALT	death
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	to Instructured, unterview in several persons been signed by the attentioning presental and uniqueneshi meet in 87 the funderal direction, page 5 should be detached for use as the burial-transit permit. Pag be filled within 72 hours afficie and with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.
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95 13785 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF OEATH MONTH
ARC 9
7. DATE OF BIRTH (Month, Day, Year) te Kees .45 4. SOCIAL SECURITY NUMBER IF UNDER 24 HRS. IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreig. June 5, 218-01-4584 DAYS HOURS 1 M 2 X F 86 YRS 1908Maryland 9e. FACILITY NAME (If not institution, give street end number, 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Harford Memorial Hospital Havre de Grace Harford RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil Perryville 1X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 548 Aiken Avenue 21903 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES NO Specify: BY 3

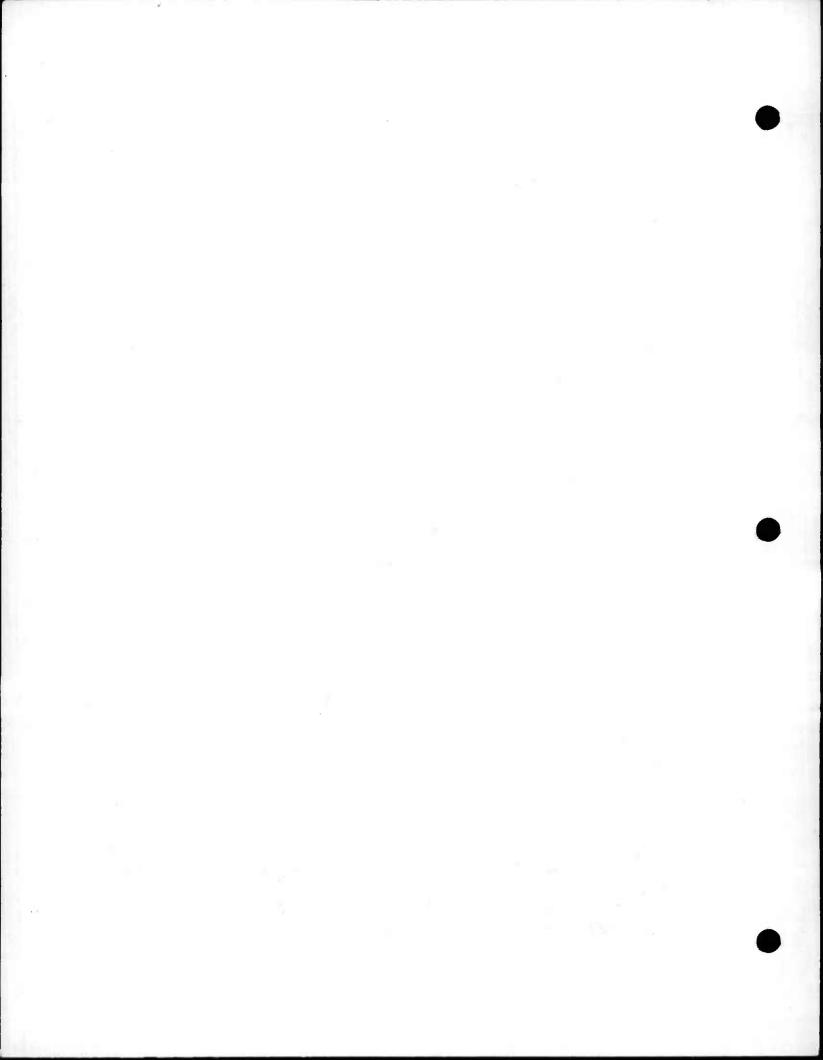
Wildowed 4 □ Divorced Specify: White COMPLETED 15. OECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Nine Years Homemaker -----17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Thomas W. Reynolds BE Sarah Estelle 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Natalie A. Adams 725 South Washington St., Havre de Grace, MD 21078 20a, METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Buriel 2 Cremetton 3 🗆 Hopewell Cemetery 4 Donation 5 Other (Specify) 4/12/95 Port Deposit, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory strest, shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition resulting in desth) Chaplos bacular Ampar CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CON if sny, leading to immediate cause. Enter UNDERLYING VEMMINA CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST Ntumonia PART ii. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 | YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO I UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only on HOSPITAL OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending investigation M ВҮ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building stc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number COMPLETED 6 Could not be Wemm 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end ple (Check only one) 2 MEDICAL EXAMINER: On the beels of examination end/or eath occurred at the time, date end piece, end due to the ceuse(s) end menner es stated. 296. SIGNATURE AND TITLE OF CERTIF BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) 9 10

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Talia Stwiller A

DHMH-18 Rev 1/89

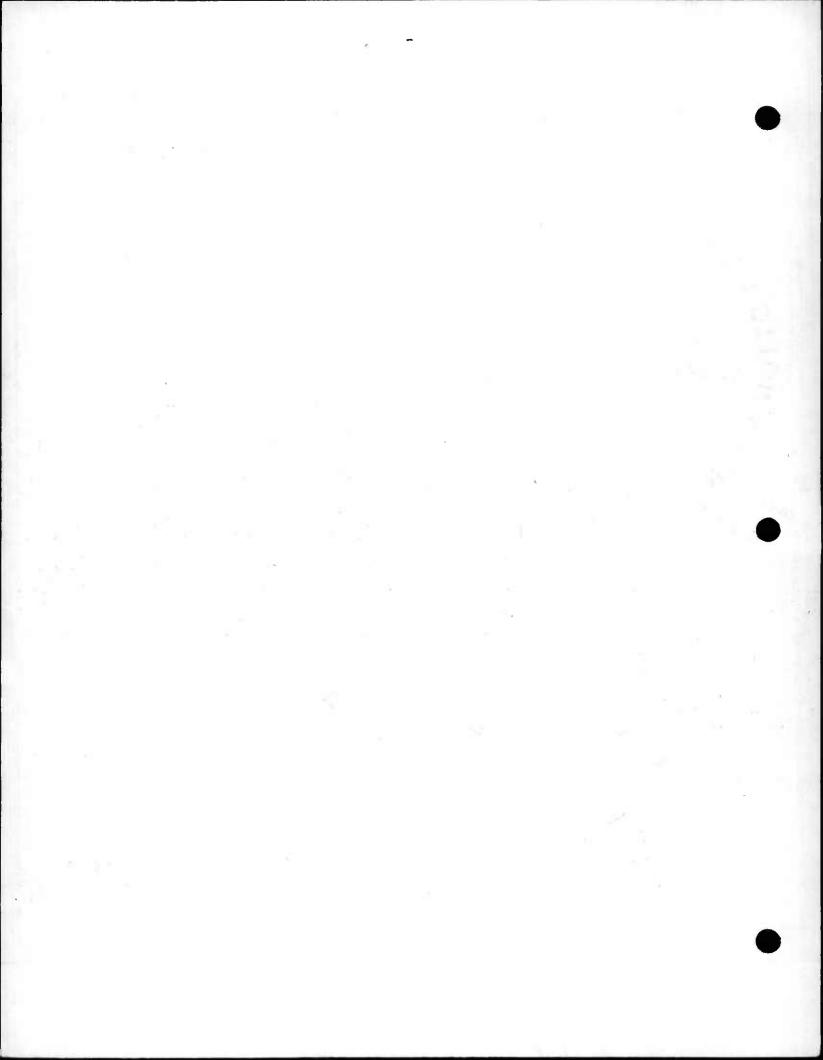
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July duwlear Kardall

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9		217-22-9662		E (In yrs. les		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Dec. Year)		Country)	LACE (State or Foreign				
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	Di l	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Y		10c CITY	, TOWN OR LOCA	TION								
	E	Maryland	Harford		IOC. CITY					1	Od, INSIDE CITY				
		10e. STREET AND NUMBER	TIGHTOTA		<u> </u>		lgewood				YES 2 ND				
	RA	AND THE TOTAL SECTION				10	f. ZIP CODE		10g. CIT		AT COUNTRY?				
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at or	_	Robert Llewellyn	Thomson					ME (First, Middle, Melden							
	BE	19a. INFORMANT'S NAME (Type/Print)	manpson					Lillian St							
notified	2	Donna K. Edwards						Poute Number, City or Tow							
a l	.	The second second		4.	300 1	vorrisvi	TTe Road	, White Ha	11, 1	$^{\prime}$ 1d 2	1161				
must		20e, METHOD OF DISCONTION 20b. PLACE AND DATE OF DISPOSITION (Name of Semilar of Semil													
		Bel Air Memorial Gardens 4-12-95 Bel Air, Maryland													
ı. examiner		21. SIGNATURE OF TUNERAL SERVICE COONNEES 22. NAME AND ADDRESS OF FACILITY													
_ E		Howard K. McComas III Funeral Home, P. A. III Cokesbury Road, Abingdon, Md 21009													
Mental Hygiene prior to burial, cremation, or removal ijury, or other traumatic event, the medical or		23 PART I. Enter the digesses, of	complications that cause	ed the de	ath. Do n	Ot enter the mo	de of dving auci	as cardisc or resol	retory or	7 110					
med ne		23 part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, abock, or heart fallers. List only one cause on each line. Approximate interval Batween													
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State Dept. of Health a item 23 shows any	ICIAN	EXAMINER?		1 UPES 2 PD 1 Input 2 ER/Outpetlant 3 DOA 4 Nursing Home 8 Residence 6 Other (Specify)											
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burs after death. Page 6 may be retained by the hospital or attending physician. I in by the tuneral director, page 5 should be detached for use as the burial-trans BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within TIT THE FILINERAL DIRECTIONS. After this certificate has been sinned by the attention physician and committee

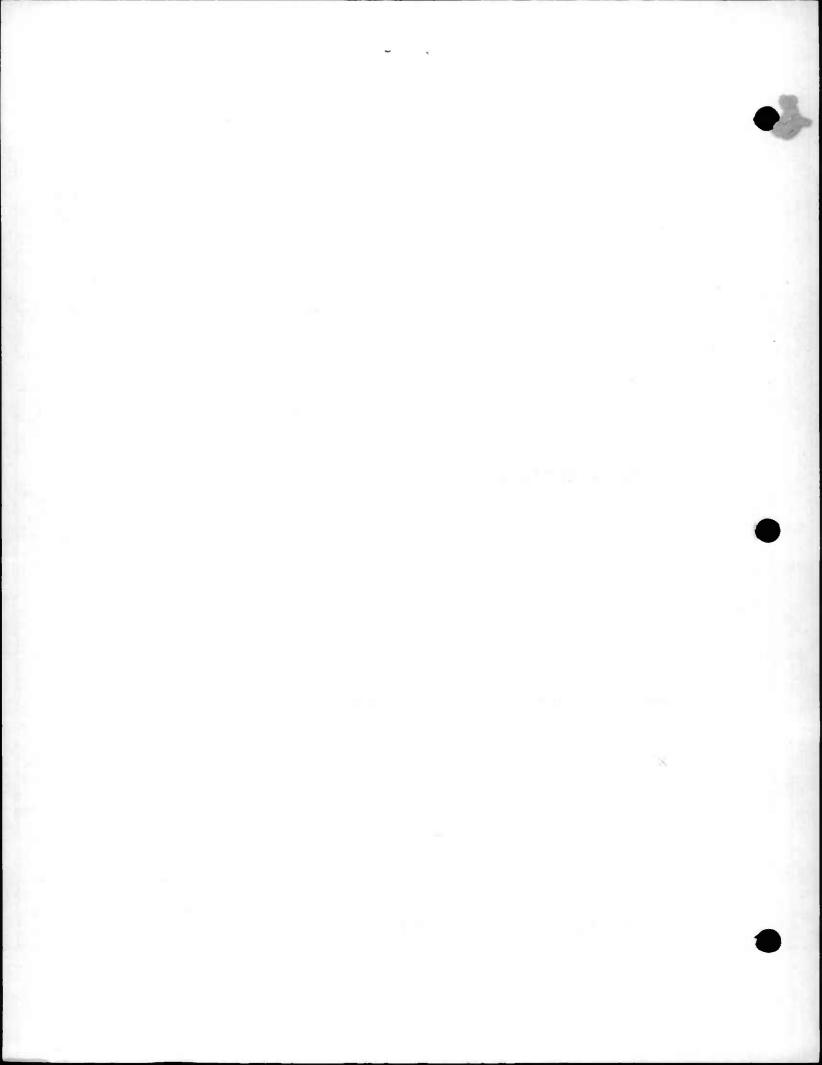
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						OLIT	111 10		<u> </u>	DEAL	* 1		IEG. NO.			
		MONTH DAY YEAR									3. TIME OF DEATH					
		4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In yrs.		yrs. last birth	oday) IF	UNDER 1 Y	EAR:	7			April 17, 19		95 220 P M 8. BIRTHPLACE (State or Formign	
D.		216-07-4740		1 🖫 M 2 🗆 F 87			RS. MOI	THS D	DAYS HOUF		MIN.	Feb. 5, 19		Country)		le Island
bunal-transit permit. Pages 1, 2, 3 should	E.	9m. FACILITY NAME (# not insti Dennett Roa			no Ho	nme	96	. CITY, TO		aklan						
1. 2,	5	RESIDENCE OF DECE					u			Gai	rett					
Sage	DIRECTOR		10b. COUNTY			100	city, to									10d. INSIDE CITY LIMITS?
		MD 10e. STREET AND NUMBER		Garrett		Oal										1 YES 2 NO
<u>8</u>	FUNERAL	608 Mitchel	ll Lane				101. ZIP CODE					21550		US.	HAT COUNTRY?	
- II- II-	NS	11. MARITAL STATUS		12. WAS DECEDEN			XNO If yes, spec			ECENDENT OF HISPANIC ORIGIN? (Specify Yes				or No. 14. RACE — American Indian		
and and	ВУ Б	1 Never Married 2 M 3 Widowed 4 Divorc		FORCES? 1 IF YES, GIVE W						specify Cuban, Mexicen, Puer FES 2 X NO Specify:			ruerto Ricen, etc.)			, While, etc.
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once.	SO	17. FATHER'S NAME (First, Midd					18. MOTH	ER'S NAI	ME (First, Midd							
ed at	BE	William	F.	Lee								scilla			-	Deahl
notified	5	196. INFORMANT'S NAME (Type Lillian M.							Route Number, Oakla			21550				
9	ŀ	20s METHOD OF DISPOSITION	N	TOTAL STATE		LACE AND D	ATE OF D	SPOSITION	N /Na	me of		DATE	v		Cily or Tov	vn, State
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examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE								D ADDRES			me			
exa l		Buddy		Stewart Funeral Home 32 S. Second St., Oakland, MD 21550												
nation, or removal.		23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory erreat, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Congestive Heart Failure Approximate Interval Batween Onset and Deeth Days														
even	CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):														
Health and Mental Hygiene prior to burial, cremation, ws any Injury, or other traumatic event, the		Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
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5 6													1 _ YES 2 _ NO			
Oept. 23 s	AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)														
State Oept.	PHYSICIAN:	EXAMINER?		HOSPITAL:	FR/Outpati	lent 3 🗆 D	01	WER:								
d, or	Ä	27. MANNER OF DEATH		28a. DATE OF	□ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. DATE OF INJURY 28b. TIR				c. INJ	JRY AT	Idence	8 ☐ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED				
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E 20	60	3 Suicide 8 Co	At home, fo	erm, stree	t, fectory	office				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
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filed within 72 hours PORTANT: If Item	COMPL	29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and dus to the cause(s) end manner se stated.														
Within	- 11	2 MEDICAL EXAMINER: On the basis of exeminstion end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) end menner as stated.														
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		Dr. Jerry A	dams,	MD 31	1 N.	Fourt	h St	., (Dak	land	, Ma	rylan	1 21	.550		
	//	31. DATE FILED (Month, Day, Ye.		32. REGISTRA	R'S SIGNAT	URE	-					,				
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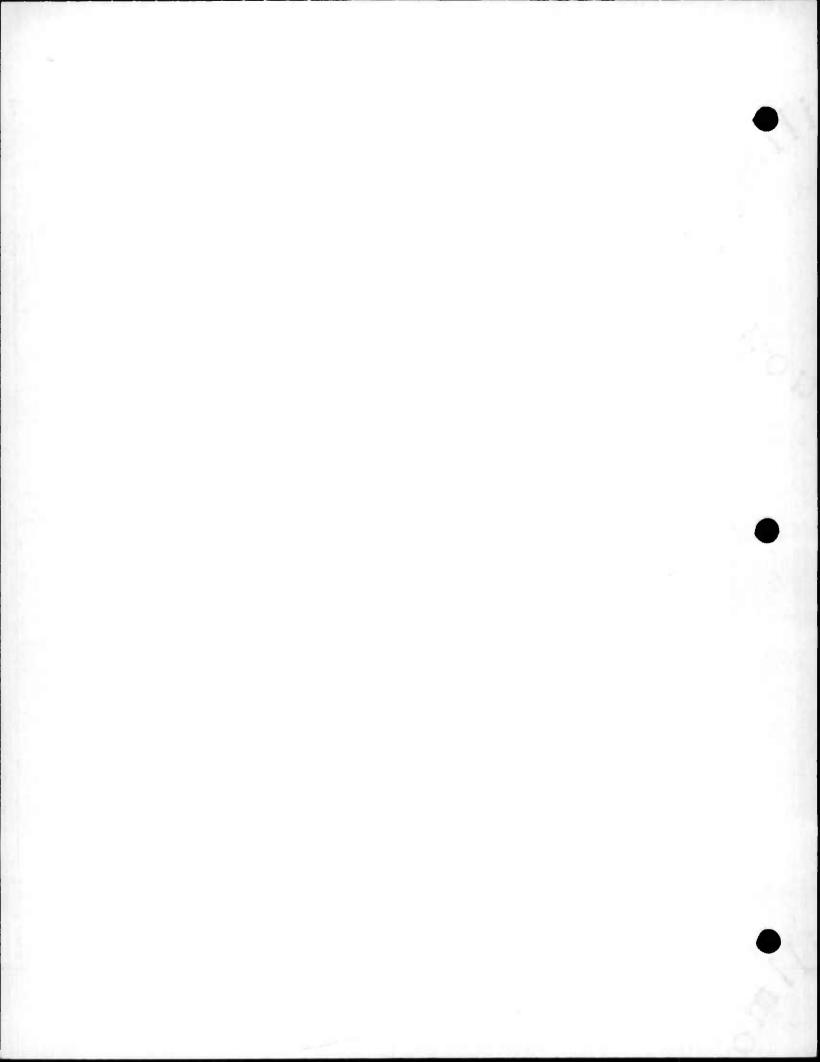
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		FOR 1 STATE		STATE OF I	MARYLA							MENT/	AL HYGIEN	E		
		REGISTRAR 1. OECEOENT'S NAME (First	Middle Lust)			CEF	31 IF	ICATE	OF	DEA	IH	1 DAT	REG. NO.		1,). TIME OF DEATH
	1	Frederick Alfred LOHR											TH DA	YEAR	1000	
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permit. Pages	DIRE	MD	Ga	rrett			S	wanto	on						1	LIMITS?
E e	1AL	10s. STREET AND NUMBER			•		101. ZIP CODE 10g. CITIZEN OF WHAT COUNT									AT COUNTRY?
020 physician. burial-transit	FUNERAL	225 Sky V	alley										1561	<u> </u>	USA	
hysici nurial-l	교	11. MARITAL STATUS 1 Never Merried 2	U.S. ARME 2 XNO	0	- 11	yes, sp	ecify Cube	n, Mexica	n, Puerto	IN? (Specify Yes Ricen, atc.)	14. RACE - Black,	- American Indian, White, etc.				
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MARYL. retained by th 5 should be c	8	19e. INFORMANT'S NAME (7	ype/Print)			19b. N	WAILING	AODRESS	(Street e				mber, City or Town	n, State, Zip		rien
		Frederick	E. Loh	ır									Swanto			nd 21561
IIMOHE, MAR I. Page 6 may be retained ral director, page 5 should liner must be notified		20e. METHOD OF DISPOSIT		oval from State		PLACE AND			TION (Na	rne of		OA	TE 20c. LO	CATION -	City or Town	1, State
MOR age 6 ma director,		Alexander Lohr Cem. 4/17 Swanton, MD														
GALIMOR ter death. Page 6 m the funeral director, wal.		22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home														
after death by the fune moval. ical exam		32 S. Second St., Oakland, MD 21550														
S E e		23. PART i. Enter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory erreet, shock, or heert feiture. List only one cause on each line. Approximate interval Between														
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U.S., F.O. B.C. be death certificate the attending physic Mental Hygiene pri njury, or other to	빙	d														
	AL.	PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO											VERE AUTOPSY FINOINGS			
uires that the signed by the Health and I health and I has any Inj	MEDICA							_					1 TYES 2		0	OMPLETION OF CAUSE OF DEATH?
requires seen sign shows	×	DID TODAGO	0 1105												1	YES 2 NO
has b Dept.	A A	DID TOBACC		CONTRIBUT	F 10	CAUSI	E OI	DEA		ACE OF 0	NO	700				
N: The ficate State	SC	EXAMINER?		HOSPITAL:	ER/Outpa	etlent 3 🗆	DOA	OTHER	:				ner (Specify)			
YSICIA S certif th the		27. MANNER OF DEATH		28e. DATE OF	_		28b. TIM		28c. INJ	URY AT	reiderice		ESCRIBE HOW II	NJURY OC	CUREO	
DING PHYS After this death with	BY		Pending Investigation	(MOM), E	ray, reary		1113	M		RK? YES 2] NO					
ENDIN SR: Aff			Could not be	28e. PLACE (building	of INJURY - , etc. (Specif	- At home,	, ferm, a	ntreet, fecto	ory, office	•		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
DIVISION DIRECTOR: After hours after death	liu l		Gatterninine G													
				CIAN: To the beat of												
HOSPITAL FUNERAL within 72	8	A		1	xamination	end/or Inve	eatigatio	n, in my o	olnion, d				te end plece, en	d due to th	ne ceuse(e) e	and menner ee stated.
물 물을 뜻	出	296. BIGHATORE AND TITLE	OF CERTIFIE	1.	17	-	2	A			ENSE NUI	_				Month, Day, Year)
30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print))565	<u> </u>		Ap	oril	15, 1995			
		Herbert H.							ree	t, 0a	ak1aı	nd,	Maryla	nd 2	21550	
		31, DATE FILED (Month, Day,	Year)	39. REGISTR												
	0	APR 1 9	1995	Jalia da	uchor	Marka	4									



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	1 - FOR STATE OF MARYLAND / CE	DEPARTMENT OF HEALT ERTIFICATE OF DEA	TH AND MENTAL HYG	
	1. DECEDENT'S NAME (First, Middle, Last) S. Stratton	Lange	2. DATE OF DEAR MONTH April	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les 577-07-1098 1 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★	YRS. WONTHS DAYS HOUR	DER 24 HRS. 7. DATE OF BIRT	H 8. BIRTHPLACE (State or Foreign Country)
OR	9a. FACILITY NAME (# not institution, give street and number) Holy Cross Hospital	96. CITY, TOWN OR LOCA Silver Sp		9c. COUNTY OF DEATH Montgomery
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MD Montgomery	10c. CITY, TOWN OR LOCATION Chevy Cha	356	10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 4722 Merivale Road	10f, ZIP CO		1 ½ YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? U. S. A.
B	11. MARITAL STATUS 1 Never Merried 2/ Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 X YES 2 N IF YES, GIVE WAR OR DATES		T OF HISPANIC ORIGIN? (Speciluban, Maxican, Puarto Rican, at	fy Yes or No- 14. RACE - American Indian.
COMPLETED	(Specify only highest grade completed) (Gill Elementary/Secondary (0-12) College (1-4 or 5 +)	CEDENT'S USUAL OCCUPATION five kind of work done during most of wo Do NOT use retired.)	orking	F BUSINESS/INDUSTRY
₩ D		chasing Agent		onary Company
	17. FATHER'S NAME (First, Middle, Last) Oscar G. Lange, Sr.		other's name (First, Middle, M. Lizabeth End)	
BE		D. MAILING ADDRESS (Street and Num.		
2		22 Merivale Rd.		
	1 Burisi 2 & Cremation 3 Removal from Stata cametery, cres 4 Donation 5 Other (Specify) Mount	AND DATE OF DISPOSITION (Name of matory or other piece) Comfort Cremato	ory 4/19 A	c. LOCATION — City or Town, State Lexandría, VA
a a a a a a a a a a a a a a a a a a a	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Plan M Leturo	5130 WI A	ness of facility Josep Live. NW Washir	oh Gawler's Sons ngton, D.C. 20016
on and the	23. PART. Entar the diseases, or complications that caused the da shock, or haart failure. List only one cause on each line IMMEDIATE CAUSE (Finel disease or condition resulting in death)	· 8	dying, such as cardiac or i	reapiratory srreat, Approximats interval Between Onset and Daath
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	HUUS C	lesease	
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUENCE OF):	y seem	and the second
CALC	PART II. Other significant conditions contributing to death but not re	eaulting in the undarlying cause		S AN AUTOPSY 24b. WERE AUTOPSY FINDINGS
MEDIC				RFORMED? S 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT		ICERTAIN 🗆	
SICI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3	E OF OEATH (Check only one) OTHER:		
H	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. INJURY AT	Rasidence 6 Other (Specify, 28d, DESCRIBE H	OW INJURY OCCURED
BY F	1 Natural 5 Pending 2 Accident Investigation	M 1 YES 2	□ NO	
8	3 Suicide 8 Could not be detarmined 28a. PLACE OF (NJURY — At hor building, etc. (Specify)	ne, farm, street, factory, offica	28f. LOCATION (SI City or Town, S	ireet and Number or Rural Route Number, State)
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deal one) 2 MEDICAL EXAMINER: On the basis of examination and/or in			
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER A SIGNATURE AND TITLE OF CE	Mes	D23/76	29d. DATE SIGNED (Month, Day, Year) April 17, 1995
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM Gita C. Bakshi, M.D. 9406 Old	Georgetown Rd.	Bethesda, M	Id. 20814
	31. DATE FILED (Month, Day, Year) APR 18 1995 Julia d'Auteleure			



Pages 1, 2, 3 should

permit.

ed for use as the burial-transit

detac		once
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5 should		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defact	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Roger 55 D Bernard oiselle April 995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)
May 16, 8. BIRTHPLACE (State or Foreign DAYS HOURS 577-22-5057 1 X M 2 | F 75 Voc 1919 Massachusetts 9a. FACILITY NAME (ti not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 17060 Kings James Way 20877 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) ВУ 1 YES 2 NO Specify: 3 Widowed 4 Divorced Specify: White 1940-1945 COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 4 Artist Art 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Damose Peter Loiselle Rose Delima Unknown 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lisa Y. Hood 5450 Watts Road, Conway, South Carolina 29526 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Gate of Heaven Cemetery4/19/95 Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 23. PART I. Enter the diseases, or complications that cause the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DENTRIEWURR FIRRICIPTION 30 MWUTEN DUE TO (OR AS A CONSEQUENCE OF): UKRAIOMIOPETH 15CHEALC 10 YEARS CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING HTPOTRALE CARRIED FALCIR CAUSE (Disease or Injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any 1 | YES 2 | NO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending м 1 YES 2 NO В 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 1997 2

ROCKULYE

ESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

8 1995

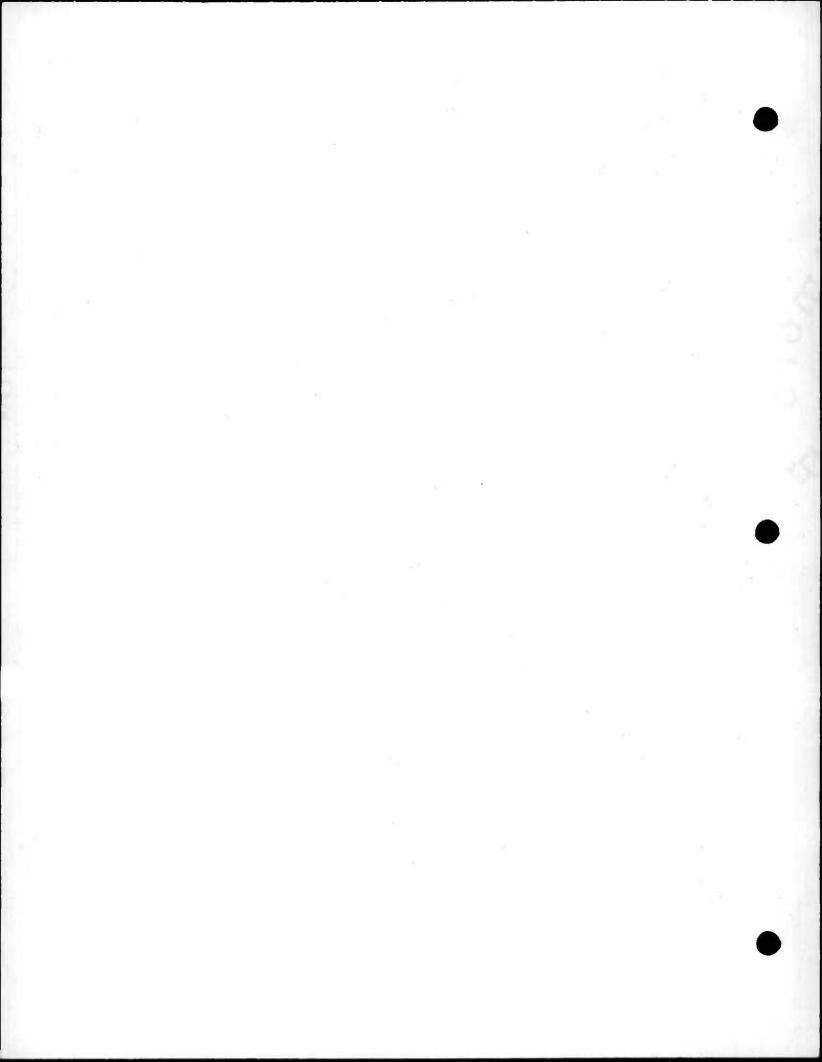
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32. REGISTRAP'S SIGNATURE



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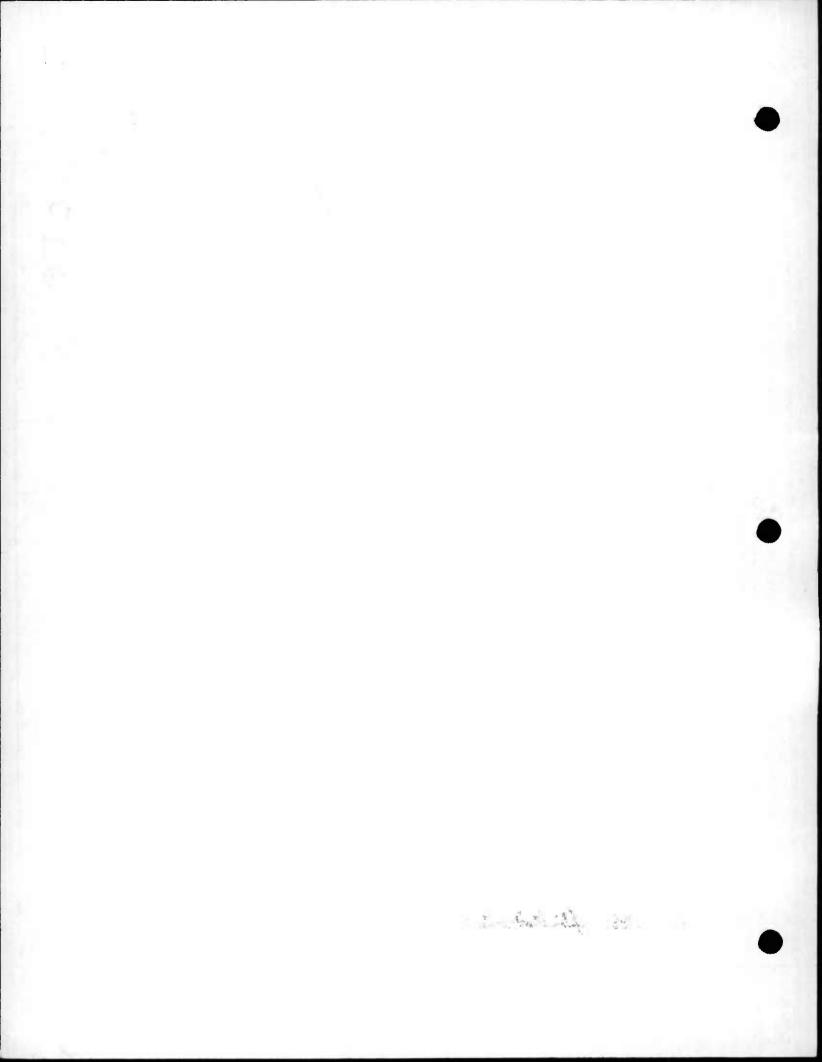
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

y		1. DECEDENT'S NAME (First Charles Lav		Langens	tein						2. DATE OF MONTH	DEATH	**	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in yrs. les	t birthdey)	IF UNDER	YEAR	IF UNDER	24 HRS.	April 7. DATE OF	BIRTH		195	D&D5 M PLACE (State or Foreign
D.		705–10–493		1 🔀 M 2 🗌 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct.2	as Mari		Country	ryland
2, 3 should	<u>ر</u>	9e. FACILITY NAME (If not in					9b. CITY,	TOWN (OR LOCATI	ON OF DE	EATH		9c. COUN	TY OF D	EATH
	ECTOR	Washington	COUNT	y Hospit	al			Hag	erst	own			Was	hing	gton
Pages	DIRE	Morry Land	10b. COUNTY			10c. CITY	, TOWN O	R LOCAT	TION						10d. INSIDE CITY LIMITS?
ermit.	AL D	Maryland 100. STREET AND NUMBER	wasn	ington			На		S LOW				L son CITIZ	EN OF W	1 YES 2 NO
n. ansit pe	FUNERA	309 Ridge	Avenue							740			US		HAI COUNTRY?
ing physician. the burial-transit permit.	BY FUR	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		FORCES?	NT EVER IN U.S. ARI I YES 2X N MAR OR DATES		l H	yes, sp	DENDENT CONCERNS 2 1 NO	n, Mexice	IIC ORIGIN? (S n, Puerto Rica /:	Specify Yea in, atc.)	or No-	Black Specif	- American Indian, , White, etc.
attending ise as the	E		EDENT'S EDUC		16a. DE	CEDENT'S I	USUAL OC	CUPATIO	ON of working		16b. KI	ND OF BUS	SINESS/INDU		viite
retained by the hospital or attending 5 should be detached for use as the notified at once.	PLET	Elementary/Secondary (0		College (1-4 or 5	+) #fe.	Do NOT use	retired.)		OSE OF WORKE	rg		roi	1road		
the hospital detached fo once.	COMPL	17. FATHER'S NAME (First, M				FEFE	1100		18. MOTI	HER'S NA	ME (First, Midd			_	
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y be retained by vage 5 should be be notified at	5	Hazel L. La	ingenst	tein		309 R	lidge	Av	e., 1		Route Number,	, Md	. 217	40	
e 6 ma rector, p must		20a. METHOD OF DISPOSIT 1 X Burlel 2 Cremetto 4 Donation 5 Other	n 3 🗆 Reme (Specify)		20b. PLACE A competery, cree ROSE	ND DATE O	r disposi her place) Cen	ete	ry	4-	20-95		cation - c ersto		en, State Taryland
death. Pag e funeral di l. examiner		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		1			CH F		AL HOM	E			
		200	4/	11/11	nnec	K	41	5 E	.Wil	son :	Blvd.,	Hag	ersto	wn,	Md. 21740
tted within 24 hours-after completely filled in by the fial, cremation, or removal event, the medical		23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart failure.	ASP	OR AS A CONSEC	F	7/6		100			or respi	ratory arre	st,	Approximate Interval Between Onset and Dasth Month
eruncate be exect ing physician and giene prior to bur other traumati	ERTIFICATION	Sequentially list condition if any, leading to immecause. Enter UNDERLY! CAUSE (Disease or injuthat initiated events resulting in death) LAS	diate NG ry		(OR AS A CONSEC										
attendi	S														
signed by Health an	MEDICAL		carc	inoma	of th	e f	tas	rta	te		1	PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
- o . oo	AN.	DID TOBACCO U		RIBUTE TO CA] UNC	ERTAIN	1 🗆 📗				11
Sician: the law requestions of the State Dept. of them 23 shots.	SICIAN:	EXAMINER?	MEDICAL	HOSPITAL:	ER/Outpatient 3		OTHER			-14	* /				
NDING PHYSICIA I: After this certif r death with the Is marked, or	PHY	27. MANNER OF DEATH	Pending	28e. DATE OF (Month, E	INJURY	28b. TIME	OF	28c. INJ	URY AT		8 Other (Sp 28d, DESCRI	-	JURY OCC	JRED	
2 at 2	red BY	3 Suicide 6	nvestigation Could not be Setermined	28e. PLACE C building,	OF INJURY — At hor atc. (Specify)	ne, ferm, st	reet, facto			3.02	28t. LOCATIO	N (Street e	nd Number o	r Rural Ro	oute Number,
RAL DIRECT TO HOURS TO HOURS	COMPLETE				my knowledge, des										
	BE CO	296. SIGNATURE AND TITLE		_	ALIMINENON GROUPS		, in my op	imon, o		NSE NUM		place, en			end menner ee stated. (Month, Day, Year)
TO THE De filed	TO B	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	MD SE OF DEATH (ITEM	27) (Type. I	Print)		04	291	5		14	-1	7-95
		D.E.An	1600	0.1111	O Me	(((ca		cen	nous	-15	7 +	ege	rstov	010	Md 21742
		rk 1 3 1995	Jama	The state of the	R'S SIGNATURE							7			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020



DIVISION OF VITAL RECORDS, P.O. BOX 68760, DALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

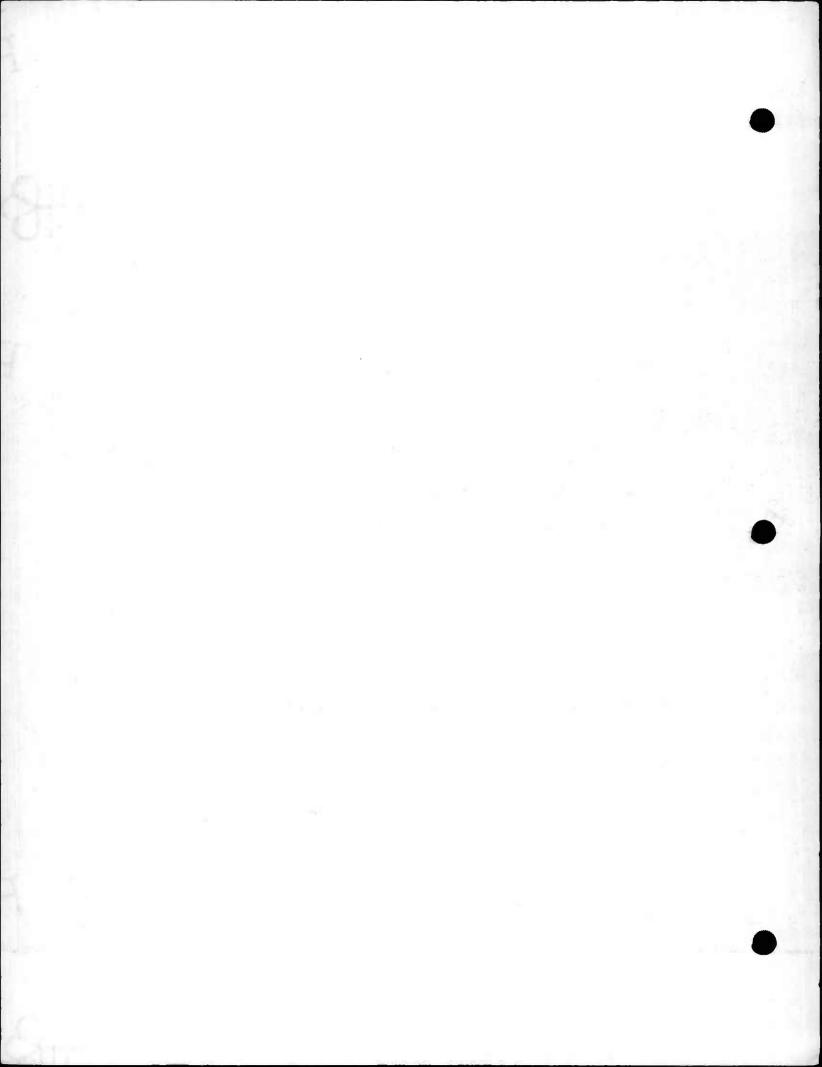
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1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			EHIIF	CALE	UF	DEA	l ITI	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF I	DEATH	NY.	YEAR	3. TIME OF DEATH
		Jean B	. Lo	ng					Apri1	14			4:15 1.1M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs.	last birthday)	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF E (Month, Da			8. BIRTH Countr	PLACE (State or Foreign
	549-34-3373	1 🗆 M 2 💢 F	66	YRS.	MONTHS	DATE	HOUNS	MIN.	Sept.		1928		
	9a. FACILITY NAME (If not institution, give str	eet and number)			9b. CITY,	TOWN C	R LOCATI	ON OF OE				NTY OF D	
R I	404 Park Place				E1k	ton					Cec	i1	
ธ์ l	RESIDENCE OF DECEDENT												
DIRECTOR	10a. STATE 10b. COUNTY				Y, TOWN OF	LOCAT	ION						10d. INSIDE CITY LIMITS?
	Maryland Cecil			E11	kton								1 X YES 2 NO
A	10e. STREET AND NUMBER	-				101	. ZIP COD	E			10g. CIT	IZEN OF V	VHAT COUNTRY?
띪	404 Park Place						2192	1			U.	S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT							C ORIGIN? (S		or No-	14. RACE	— American Indian, c, While, sic.
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WAI		ŽΝO				n, Maxican Specify:	, Puarlo Ricar	ı, etc.)		Speci	Mv:
B	3 Widowed 4 Divorced						A				7.3	-	White
	15. DECEDENT'S EDUC (Specify only highest grade of		16a. l	DECEDENT'S	USUAL OCI	CUPATIO)N et al warkir	30	16b. KIN	D OF BUS	SINESS/INI	DUSTRY	
Ξ.	Elementary/Secondary (0-12)	College (1-4 or 5+)		ife. Do NOT us	se retired.)	ang mo	SE OF WORKE	'S					
필	12		H	omemal	ker								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NAM	AE (First, Middl	e, Maiden	Surname)		
BE	Jason Broo	ks Beall							Mary	Love	na B	isho	D
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a	nd Number	or Rural A	oute Number, C				
임	Dan L. Long								on, MD		921		
	20a. METHOD OF DISPOSITION		20b. PLAC	E AND DATE	OF DISPOSIT	TION (Na	me of		4 ^{DA} 1 ^E 9		CATION —	City or To	wn, Steta
	1 X Burlai 2 Cremation 3 Remo	val Irom Stata	Gilpi	n Man	ther place)	nori	a1 P	ark	1995				26. 10.10.11
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE							or Fun	1	- D	A	y Land
Į	h	0			#	1CK	S HO	me I	or Fun ckton	eraı Stre	s, P	.A.	
	Donald	J. D.	Elsa.		E	1kt	on.	MD :	21921-	5521			
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that	caused the e	death. Do r	not enter t	he mo	de of dy	ing, such	as cardiac	or respi	ratory ar	reat,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel												Onset and Death
П	disease or condition resulting in death)	CN	> /	ne	195	1	48	25					
		DUE TO (C	OR AS A CONS								7		
z		INUA.	SIVE	1/0	CIA		CAR	CIM	om	Si	ZeA	37	
일	Sequentially list conditions, if any, leading to immediate	DUE TO (C	R AS A CONS	EQUENCE O	F):								
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury												
	that initiated events	DUE TO (C	R AS A CONS	EQUENCE O	F):								
	resulting in death) LAST												
	PART II. Other algnificant conditions	contributing to d	esth hut no	resulting	In the und	lerlyln	2 001100	ahran In I	Port I 244	MM C AN	AUTOPSY	0.01	WEEK ALTONOM ENDINGS
₹	and any any and any and any any	outling to a	eath but no	readiting	in the disc	errynn) cause (given in i	Part I. 241	PERFOR		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL									1[YES _2	NO	- 1	OF DEATH?
Σ									_			ı	1 TES 2 NO
ÿ	DID TOBACCO USE C	ONTRIBUTE	TO CAL	JSE OF	DEATH	+ Y	ES 🗌	NO.	2				
등	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF D	EATH (Che	ck only one)				
S	1 TES 2 NO	1 Inpatient 2 I	ER/Oulpatient	3 🗆 DOA	OTHER:		5 DA	aldence (6 🗆 Other (Sp	ecify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF III (Month, Day		28b. TIM	E OF	28c, INJ WO	URY AT		28d. DESCRI	BE HOW I	NJURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	,	, , , ,	""	М		rES 2	NO					ļ
	3 Suicide 6 Could not be	28a. PLACE OF building, et	INJURY At	ho <i>m</i> a, larm,	street, lacto	ry, offic			281. LOCATIO	N (Street a	and Numbe	r or Rumil F	Route Number,
COMPLETED	4 Homicide determined	bolloning, or	ic. (opocity)						City or it	wn, State)			
ש ו	29a. CERTIFIER L CERTIFYING PHYSIC	IAN: To the best of m	v knowledne	death occurs	ad at the tie	an data	and place	and due	15 the source			4-4	
ž	anal												and manner as stated.
8	V	1.3			,,		valii occui		inno, cata and	piece, air	G 608 10 11	in cadee(a	i) and marmer as stated.
BE BE	296. SIGNATURE AND VITLE OF CERTIFIER	um.D					29c. LICI	ENSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
0	Your Jano	/					DC	18	58		- 4	1/18	175
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (IT	~7		7.			· ·	4-	7		
	MOSERI C.	SIA	/		AIC X	CA	DA	NUC	EL	KTO	in.	ma	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR										- 1	
10	APR 1 8 1995	Julia atte	uchon-Ra	Mall									

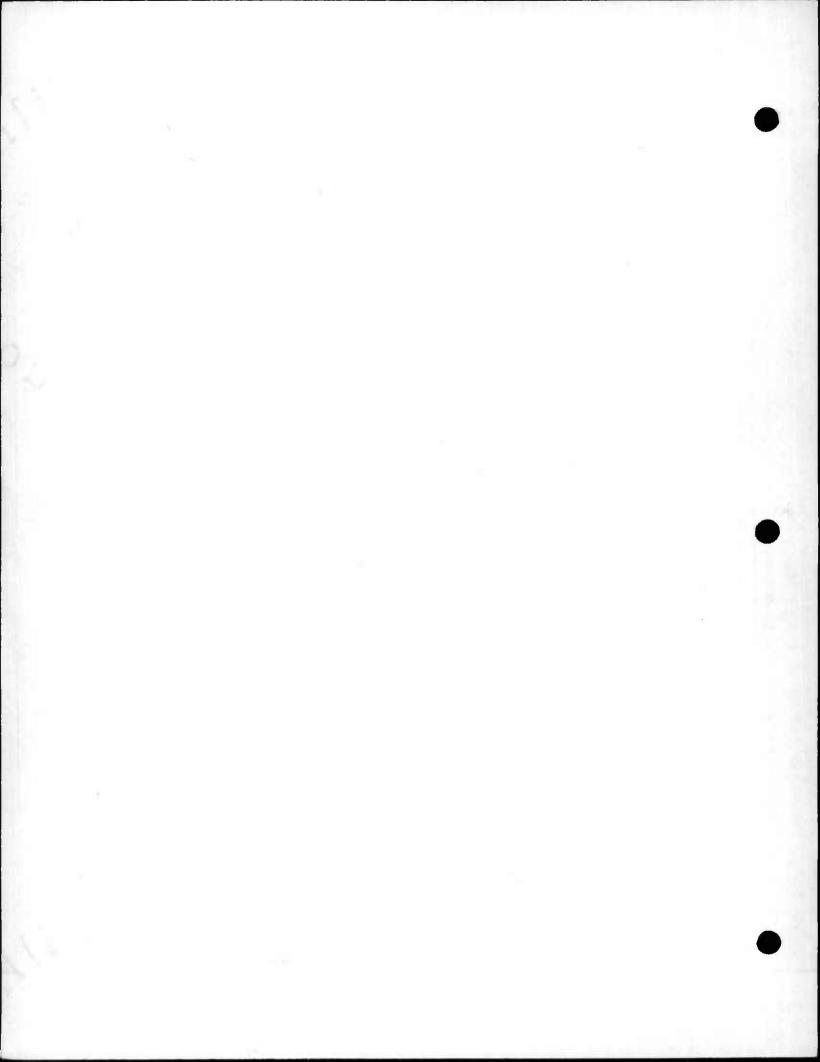
DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

S	STATE OF	MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	5.
Last)			2. DATE OF DEATH	
T.AMAN	INA		MONTH DAY	7

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)		CENTIF	ICATE OF	DEMIN	2. DATE OF D	EATH DAY		OF DEATH
	<i>LOUIS J</i> oseph <i>LAMA</i>	NNA				APRIL	11, 19	95 2:	15 PM
	000 40 0740	8. AGE (#	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI (Month, Day,	RTH Year)	8. BIRTHPLACE (S Country)	tete or Foreign
	9a. FACILITY NAME (If not institution, give stree		YRS.			JULY 2	9,1904	Wilmingt	on De
OR	LAURELWOOD NURSIN				OR LOCATION OF D		ec. cour	TT.	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCA					IDE CITY
D.R.	Maryland Cecil			kton				LIM	ITS?
FUNERAL	10e. STREET AND NUMBER			10	f. ZIP CODE			ZEN OF WHAT COU	NTRY?
JNE	1.00 Laurel Drive	2. WAS DECEDENT EVER IN	U.S.VARMED	13 WMS DEC	21921 CENDENT OF HISPA	MIC OBIONES (P.		ed State	
В	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	pecify Cuban, Maxic 3 2 X NO Spec	an, Puarto Rican,		14. RACE — Ameri Black, White, a Specify: White	tc.
TED	t5. DECEDENT'S EDUCAT (Specify only highest grade cor	TION mpleted)	16a. DECEDENT'S	vock done during my	ON ost of working	16b. KIND	OF BUSINESS/IND	USTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Pharmac		Assista	nt. Phai	rmaceuti	cal Sale	c
Š	17. FATHER'S NAME (First, Middle, Last)				T		Maiden Surname)	car sare	J
BE C	Angelo La Mann	a			Grace		stiana		
5	196. INFORMANT'S NAME (Type/Print) Margaret Ciconte						ly or Town, State, Zip		
	20a. METHOD OF DISPOSITION 1 Burlal 2 A Cremation 3 Remova		PLACE AND DATE				Delaware		
i	4 Donation 5 Other (Specify)		i Tverbro	ok Crema	atory	1995		ton,Dela	ware
	21. SIGNATURE OF FUNERAL SERVICE LICEN	97.		22. NAME A	ND ADDRESS OF F	cal Home	25		
1	Charles Franci	s Mealey	4				eet Wilm	ington,	DE
	23. PART I. Enter tha diseases, pr com ahock, or heart failure. Lia IMMEDIATE CAUSE (Final	nplications that caused it only one cause on ea	the death. Do r ch line.	ot anter the mo	ode of dyling, suc	ch aa cardlac p	or reapiratory arr	Inte	proximata erval Betw set and D
Ü	disease or condition reaulting in death)	CAD							
2		DUE TO (OR AS A	YINA!						
CATIO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A							
FICA	cause. Enter UNDERLYING CAUSE (Disease Dr Injury	DUE TO (OR AS A	CONSEQUENCE OF	31					
RTIF	that initiated events resulting in death) LAST			,.					
L CE	PART ii. Other aignificant conditions of	contributing to death bu	t ont resulting i	n the underlyin	a cause alves la	David I Date	WAS AN AUTOPSY		
ICAL			. The readining t	i the uncertying	g cause given ii		PERFORMED?		EPRIOR TO ION OF CAUS
MEDIC/						[''	TES 2 M NO	OF DEATH	? 2 □ NO
ä	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YE	S NO C	UNCERTAI	N			
SICIAN:		IOSPITAL:	6. PLACE OF DEAT	OTHER:					
PHYS	27. MANNER OF DEATH	□ Inpetient 2 □ ER/Outpet 28e. DATE OF INJURY	28b, TIM	OF 28c. INJ	URY AT		HOW INJURY OCC	URED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		PRK? YES 2 NO				
	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY - building, atc. (Specif	– At home, ferm, a	treat, lactory, offic		281. LOCATION City or Town	(Street and Number n, State)	or Rural Route Numb	er,
뼥	29s. CERTIFIER 19 CERTIFYING BUYENCIA	N. To the best of	45.4.4			l			
	(Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: C								ner aa atated
OMP	296 SIGNATURE AND TITLE OF CENTIFIER	V			29c. LICENSE NU			SIGNED (Month, Da	
E COMPL		-1/ -			D32395		_ L	PRIL 12,	
BE	20 NAME AND ADDRESS OF DEPOSAL WHILE O	*			D32333			111211 11/	1000
	30. NAME AND ADDRESS OF PERSON WHILD C				ortheast	Maryl		901	1000



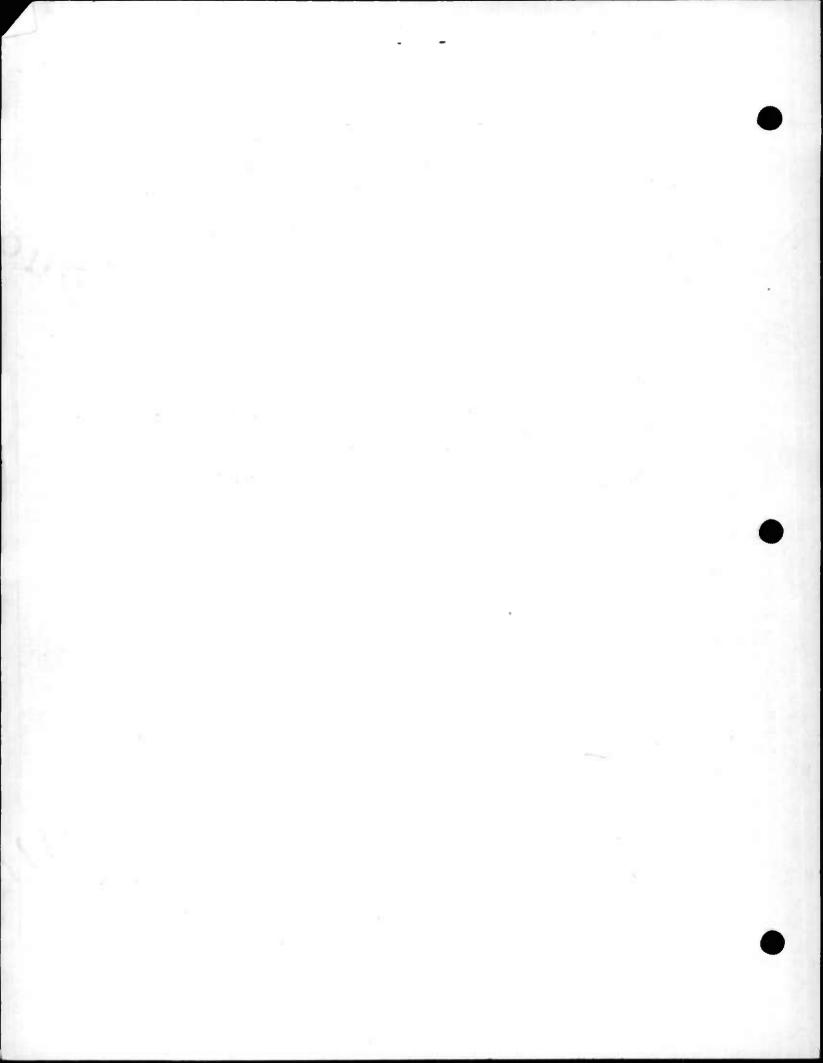
ICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	if this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit.	
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Jeath. P	funeral	
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CIAN: TI	ertificate he State	
IX.	this ce	
ᅕ	- 5	
ENDING PF	DR: After ter death	
OR ATTENDING PH	DIRECTOR: After yours after death	
SPITAL OR ATTENDING PH	VERAL DIRECTOR: After vin 72 hours after death	
) THE HOSPITAL OR ATTENDING PH	TO THE FUNERAL DIRECTOR: After to be filed within 72 hours after death	

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

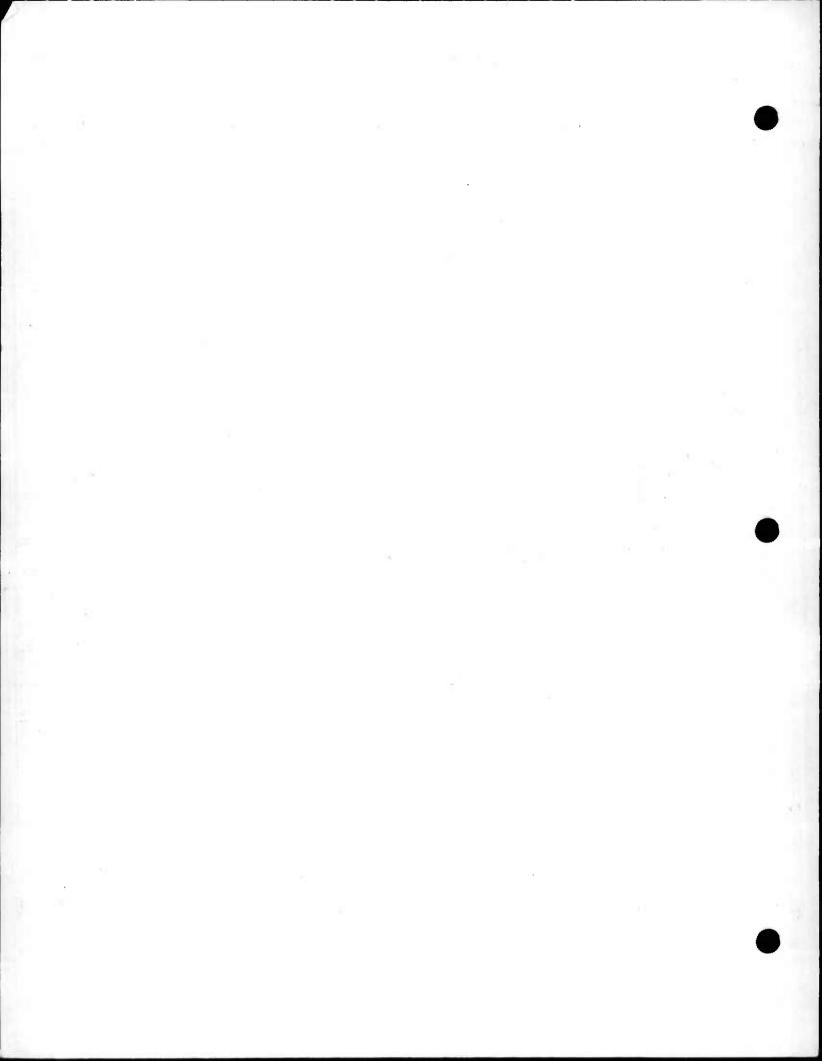
ITEMS: 23 PART I, 27, 28a-f PER MEO FILM G-723 5/19/95 t.t
23 part II
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. FOR STATE REGISTRAR

	_					~ - I I I I I	IVALL	. 01	DEMI			TEG. NO.			
		1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
		Allen		Henr	~~ 7		Mavle	_			MONTH	DA		YEAR	1.600 M
	- 1	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs				IF UNDER 2	2014 14	7. DATE OF		5 19		1600 M PLACE (State or Foreign
		IDIIAIAIAI		1 X M 2 D F		-0-1-1	MONTHS	DAYS	HOURS	MIN.	(Month, De	sy, Year)		Country	y)
		9a. FACILITY NAME (If not in			4	1 YRS.					May 4	, 19:			yland
١,	- 1	in creek	istitution, give s —	treet and number)			9b. CITY,	TOWN (OR LOCATIO	N OF DE	ATH		9c. COUN	TY OF DE	EATH
3	5	in creek Route 495 RESIDENCE OF DEC	-(Swa	nton Ro	nad)		Sv	wan	ton				Ga	rre	++
8	DIRECTOR	RESIDENCE OF DEC	10b. COUNT			T 40 . 01							1371		
2	Ĭ	MD	IOU. COOK!			10c. CI	TY, TOWN O	R LOCAT							10d, INSIDE CITY LIMITS?
				Garre	כנ				Sī	vant	on				1 YES 2 NO
13	₹	10e. STREET AND NUMBER						101	. ZIP CODE				10g. CITIZ	EN OF W	HAT COUNTRY?
1	FUNEHAL	P.O. Box 1	314							21	561			US	SA
	5	11. MARITAL STATUS		12. WAS DECEDER	T EVER IN U.S.	ARMED	13. W	AS DEC	ENDENT OF	HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian,
	- 11	1 Never Married 2			MAR OR DATES	K NO	1 14	yes, sp	ecify Cuban, 2 NO	, Maxica	n, Puerto Rice	n, etc.)	7723	Black,	, White, etc.
	2	3 Wildowed 4 XX Divo	rced				Ι.	_ 160	Y X	Specify	··			Specif	White
6	и ІІ	15. DEC	EDENT'S EDU	CATION	16a.	OECEDENT'S	USUAL OC	CUPATIO	ON		16b. KIN	ND OF BUS	INESS/INDU	JSTRY	
	<u>.</u>	Elementary/Secondary (6		College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done do se retired.)	uring mo	st of working	1					
0	ַ ן	7			"	Me	chani	C				Auto	Repa	1 -	
once.	5	17. FATHER'S NAME (First, M	iddle, Last)			- 110	Chan		10 MOTH	ED'S MA	ME (First, Midd			TI	
at once.	_	Floyd 1	Henry	May1	0									77	
20 0		19a. INFORMANT'S NAME (7		Hayı		105 MAIL IN		(0)		ori	čl. Route Number, (Hay	yes
examiner must be notified	2 ∥				- 1										
De 1		Beulah May								ıd,	0ak1ar				
12		20g METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20b. PLA	CE AND DATE	OF DISPOSIT	TION /Na	me of		DATE		CATION — C	ity or Toy	wn, State
E		4 Donation 5 Other			_ Dee	er Par	k Cen	ete	ry		4/19	De	er Pa	rk,	MD
를		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	1				D AODRES						
EX		▶ 13 · 1	0 0	Mark)						ral Ho				
- 23	\dashv	22 BART I Fater the di	211	1 Drawell		1 11 5		52 S	. Sec	ond	St.,	0akl	and,	MD	21550
8	- 1	23. PART I. Enter the di ahock, or he	eert failure.	List only one cer	use on each i	ine.	not enter t	the mo	de of dyin	g, suci	h as cerdiac	or reapli	ratory erre	st,	Approximate
E	- 1	IMMEDIATE CAUSE (FIR	al												Intervel Between Onset and Death
=	Ш	disesse or condition resulting in death)	→	HEAD I	NJURIES	COMPLIC	ATED B	Y DR	OWNING						
le le	ı	resulting in death)		4.	(OR AS A CON				0 11 11 11 11						<u> </u>
other traumatic event, the medical	.														į į
or other traumatic	Σ∥	Sequentially list conditi		DUE TO	(OR AS A CON	SEQUENCE C	WF):								
TA TA	₹	cause. Enter UNDERLY!	NG												j l
喜品	í II	CAUSE (Disease or inju that initiated events	7	DUE TO	(OR AS A CON	SEQUENCE O	F):								
or of	-	reaulting in deeth) LAS	Т				•								į į
9 Z	ÿ			d											
를 _	. II	PART II. Other significe	nt condition	s contributing to	deeth but no	t resulting	in the und	erlying	ceuse gi	ven in	Part I. 24s	. WAS AN	WTOPSY	24b.	WERE AUTOPSY FINDINGS
ows any ir	3	FATTY LIVER	DUE TO	CHRONIC AL	COHOLIS	M			0500			PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
OWS 3	9 1										- 10	YES 2	□ NO		OF DEATH?
61 5	- 14	DID TODA CCO II	CE CO												1 TYES 2 NO
23 Z		DID TOBACCO U		KIBUIE IO CA					UNCE	RTAIN	1 🗆				2. 4.1
or item	3	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. Pt	ACE OF DEA									
- 0	2	X□ YES 2 □ NO		1 Inpstient 2	ER/Outpetient	3 🗆 DOA	OTHER:		e 5 🗆 Resi	idence	Other (Sp	ecify) Ĉ	at so	cene	9
		27. MANNER OF DEATH	6	28a. DATE OF (Month, D		28b. TIR		28c. INJ			28d. DESCRI	BE HOW IN	JURY OCCU	JRED	
marked,	M	1444	Pending Investigation		4/15/95	F0UW 3:05			RK? (ES 2)()	NO	SUBJEC	T FEL	1 E D	ROWNE	ะก
12 C	- 100	2 Suistin	Could not be	28a. PLACE O	F INJURY - At			ry, office	1		281, LOCATIO	N (Street ex	nd Number o	r Burni Br	oute Number
28 I			datarmined	building,	atc. (Specify)	STRE					City or To	wn, State)	RT. 49	5 (Sh	VANTON ROAD)
EW	1 1	29a. CERTIFIER	e leaner					-	-		SWANTON				
= 4		(Check only		CIAN: To the beat of											
IMPORTANT: If ite		2 MEDI	CAL EXAMINE	R: On the basis of a	xamination and/	or Investigation	on, in my op	inion, d	eath occured	d at the t	lime, data and	placa, and	due to the	cause(a)	and manner as stated.
E C	. 1	294 SIGNATURE AND TITLE	OF CERTIFIER	0.					29c. LICEN	SE NUM	BER	T	29d. DATE	SIGNED	(Month, Day, Yeer)
5 B	,	Magnete	(hel	X(2.00									>		
≥ P	? 	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	SE OF DEATH (TEM 27) /Ton-	Print)		-0.0	M	E		Apr	cil	16 1995
		1 0 0 0 .		1.1/00	157										
	-	31. DATE FILED (Month, Day,		1 22 000000	0001	11 Pe	enn S	tr	eet.	Ba	ltimo	re.	Mary	zlar	nd 21201
16	2				R'S SIGNATURE										
-1Ψ		APR 1 9	1995	talia whe	idear Ra	ball									



Amended #1

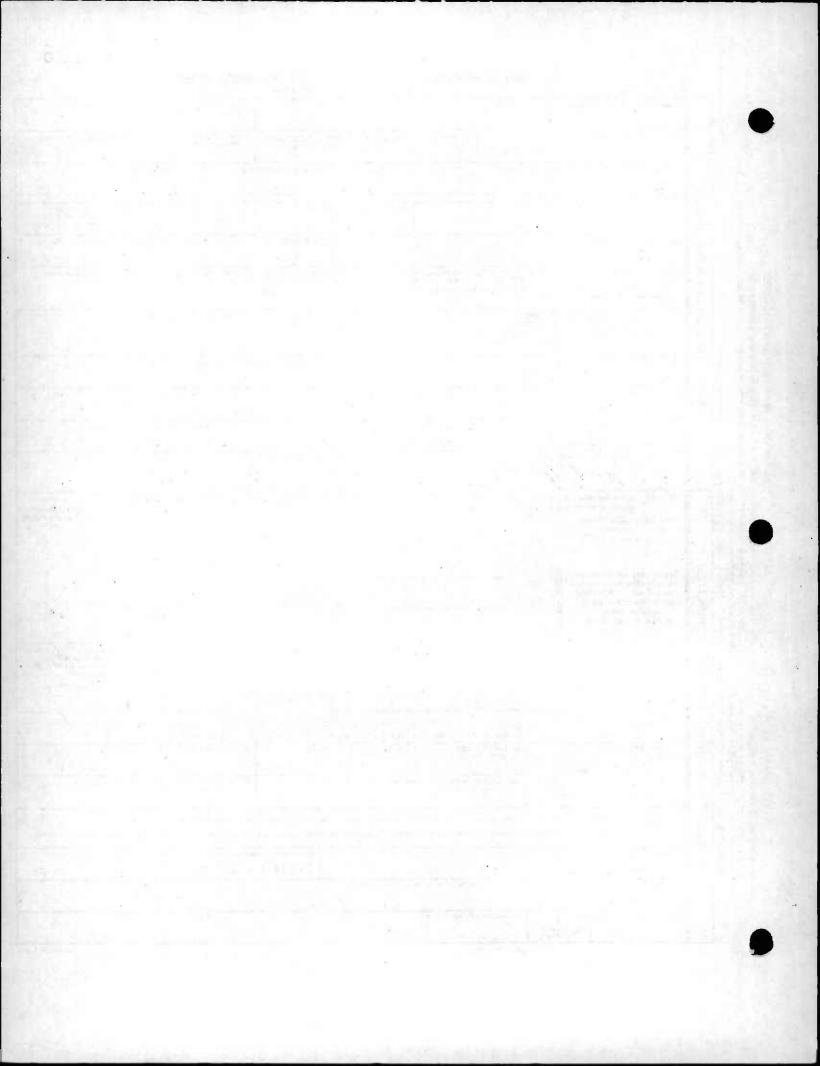
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) Murra 2. DATE OF DEATH 3. TIME OF DEATH 52000 +04 9 Der. 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR BIRTHPLACE (State or Foreign Country) DAYS HOURS 217 28 7837 1 🔀 M 2 🗌 F VRS Dec. 14,1931 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Germantown 1 TES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 18825 Darnestown-Germantown Road 20874 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puarto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Korea White 15. OECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ᄪ Elementary/Secondary (0-12) College (1-4 or 5+) 10 page 5 should be detached COMP Truck Driver Burial Vault Company once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Frederick Metz, Sr. w Mary Jane Perrell notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Ann Duvall 12519 Crossridge Way, Germantown, Maryland 20874 hours after death. Page 6 may be pe 20a. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Rea 206. PLACE AND DATE OF DISPOSITION (Ager il 19,1965) cemetery, crematory or other place) GETHERICOWN 20c. LOCATION — City or Town, State examiner must been signed by the attending physician and completely filled in by the funeral director, t. of Health and Mental Hygiene prior to burial, cremation, or removal. cemetery, crematory or other place) Gerillantown Baptist Church Cemetery 4 Donation 8 Other (Specify). Germantown, Maryland 21. SIGNATURE OF FUNERAL GERYLCE LICENSE 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 the medical 23. PART Julier the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or heert failure. List only one ceuse on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition es cle resulting in death) requires that the death certificate be executed within event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, or PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 YES 2 NO OF DEATH? 1 YES 2 - HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{2}\) PHYSICIAN: OR ATTENDING PHYSICIAN: The law this certificate has b with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tem HOSPITAL:
1 | Inpatient 2 | FR/Outpatient 3 | DOA OTHER: YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending DIRECTOR: After the hours after death v М 1 YES 2 NO В 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED 8 Could not be 4 🗍 Homicide item 28 determined 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 his important: If it (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D085 15 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8218 W18 Confin 20 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Skuller Redall 9 1995



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	Pag	9	Jer J
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Thours after death. Page 6 m	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner mus
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	PITA	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	1
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	H H	子が	THE
	10	日日	MPC
	F	FA	

	1. DECEDENT'S NAME (First, Middle, Last))			ICATE (1:	REG. N		100	3. TIME OF DEATH
	Ronald Kenneth	Mundy							April 14	199	YEAR	7:04 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER 1 YE		NDER 24 HF	$\overline{}$	7. DATE OF BIRTH		6. BIRTH	PLACE (State or Foreign
	280-28-3531	1 M 2 - F	64	YRS.	MONTHS DA	WS HOU	RS MH		(Month, Day, Year) Jan. 1,	1931	Ohi	
	9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TO	WN OR LO	CATION O				NTY OF DE	
5	Holy Cross Hosp	ital			Silve	er Sp	ring			Mon	ntgom	nerv
DINECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY		10c, CIT	Y, TOWN OR L	OCATION						10d. INSIDE CITY
	Maryland Mo	ntgomery		Ke	ensing	ະດກ						LIMITS?
	10e. STREET AND NUMBER					10f. ZtP	CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
LONEDAL	9541 East Bexhi	11 Road				20	895			Ur	nited	States
5	11. MARITAL STATUS	12. WAS DECEDEN			13. WAS	DECENDE	NT OF HIS	PANIC	ORIGIN? (Specify)		14. RACE	- American Indian,
. 13	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	IF YES, GIVE				YES 2			Puerto Rican, atc.)		Specif	y White, etc.
	15. DECEDENT'S EDI	LICATION	100	o. DECEDENT'S	HOUAL GOOD	DATION						Black
COMPLETE	(Specify only highest grad	de completed)			work done durin		vorking		16b. KIND OF B	USINESS/INI	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 5+	+)	Attor	iev				Legal			
5	17. FATHER'S NAME (First, Middle, Last)				,	16, 1	MOTHER'S	NAME	(First, Middle, Maide			
	Herbert P. Mund	У					Mat	tie	Robinso	on		
	19e. INFORMANT'S NAME (Type/Print)			196. MAILING	ADDRESS (St	reet end Nu			ute Number, City or To		p Code)	
- 11-	Mignon Mundy			9541	E. Bez	hill	Roa	d,	Kensingt	on, N	id. 2	0895
	29s. METHOD OF DISPOSITION 1/ Burlel 2 Cremetton 3 Ren	moval from State		ACE AND DATE					DATE 20c. t	OCATION —	City or To	wn, State
- 0-	4 Donation 5 Other (Specify)		Par	klawn M					9/95 Ro	ckvil	lle.	Maryland
-1	21. SIGNATURE OF FUNERAL SERVICE LI	MIN IN		-		E AND AD			m L Service	Tme		
	youn 111	11/1	nn	2	7400	Geo	rgia	Av	re. N.W.,	Wash	ingt	on. D.C.
	23. PART I. Enter the diseases, or ehock, or heart fallure.	complications the	t caused th	- death De								
-1	onoun, or most tailure.		ice on each	le death. Do	not entar tha	mode of	dying,	nuch (na cardiac or res	piratory ar	rest,	Approximate
- 11	IMMEDIATE CAUSE (Finel	. List only one ce	use on each	line.	not entar the	mode of	dylng,	nuch (na cardiac or res	piratory ar	rest,	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)		use on each	o line.		mode of	dylng,	uch (na cardiac or res	piratory ar	rest,	Approximate Interval Betwee Onset and Da
	disease or condition	Cardi	opulmo	line.	rrest	mode of	dylng,	nuch a	nn cardiac or res	piratory ar	rest,	Approximate interval Betwee Oneet and Da Immedia
	disease or condition resulting in death)	Cardi	opulmo	onary A onsequence o	rrest	mode of	dying,	nuch (aa cardiac or res	piratory ar	rest,	Approximate interval Betwee Oneet and Da Immedia
NI COLLEGE	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Cardi	opulmo	o line. Onary A	rrest	mode of	dying,	nuch (aa Cardiac or res	piratory ar	rest,	Approximate Interval Betwee Onaet and Da Immedia
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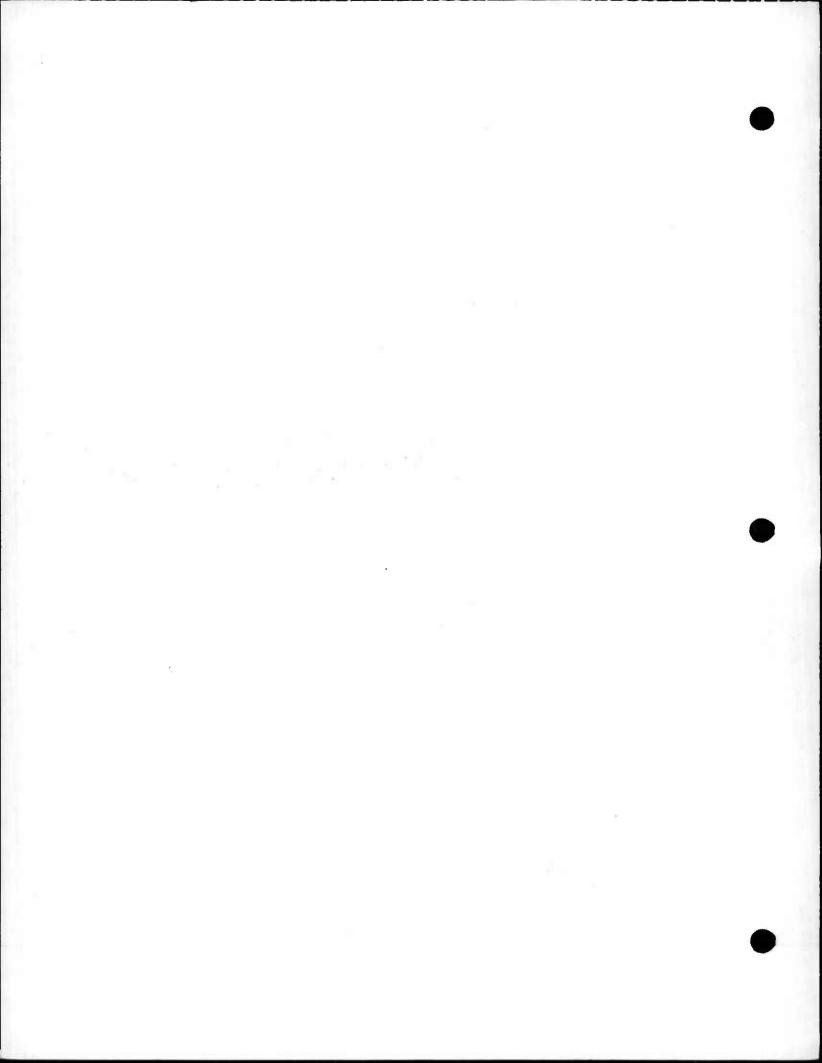
BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with pours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 1 -

	1. DECEDENT'S NAME (First,	Addedin Lond									REG. NO.	-			
	I. DECEDENT S NAME (FIRST,	MIOGRE, CLEST)			-1 1 1					April 14, 1995			3. TIME OF DEATH		
	4 00011 05011			H. Mars								T99		2:00 P m	
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. las		IF UNDER	1 YEAR	HOURS	MIN.	7. DATE O	Day, Year)		8. BIRTH Country	PLACE (State or Foreign	
	224-62-5905		1 🗆 M 2 🔀 F	99	YRS.						18, 1			sylvania	
ec	90. FACILITY NAME (II not in Med Bridge N	ledica.	reet and number) L & Phys:	cal		9b. CITY,		R LOCAT		EATH		9c. COU	NTY OF O		
<u>P</u>	Rehabilit		Center				Wh	eato	n				Mont	gomery	
DIRECTOR	10e. STATE	10b. COUNTY	,		10c. CITY	r, TOWN O	R LOCAT	ION						10d. INSIDE CITY	
뜽	Maryland	Mont	gomery		C	hevy	Ch							LIMITS?	
=	10e. STREET AND NUMBER	HOHE	gomery		1 0	nevy		ZIP COD	E			10a. CIT	IZEN OF W	1 YES 2 X NO	
B.	3805 Will	iame T	ane		20815						United				
FUNERAL	11. MARITAL STATUS	Lants D	12. WAS DECEDEN	T EVER IN U.S. AF	IMED	13. 1	MAS DEC			NIC ORIGIN?	(Specify Yea				
	1 Never Married 2		FORCES? 1	YES 2 1	ES 2 NO It y			yes, specify Cuban, Maxican, P ☐ YES 2 NO Specify:			n, Puerto Rican, etc.)			ACE — American Indian, lack, White, atc.	
B	3 Widowed 4 Divo	1 ☐ YES 2 ☑ NO Specify				Specif			White						
	15. DEC (Specify only	EDENT'S EOUG y highest grade	CATION completed)		ECEDENT'S USUAL OCCUPATION				16b. F	16b. KINO OF BUSINESS/INOUSTRY					
	Elementary/Secondary (0	ive kind of work done during most of working b. Do NOT use retired.)													
MP	12	Homem	omemaker					Own	Home	9					
COMPLETED	17. FATHER'S NAME (First, M		16. MOTHER'S NAM					ME (First, Mic	dde, Maiden	Surname)					
BE	Washington E. Hilsee Annie Lutner														
0	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
	Edward L. Marshall, Jr. 3805 Williams Lane, Chevy Chase, Marylan										rylan	d 20815			
	20a. METHOD OF OISPOSITI	n 3 🗆 Remo	oval from State	20b. PLACE	AND DATE O	F DISPOS	Apr	11º 25	5, 19	995DATE			City or To	1711000	
	4 Donation 5 Other		AVEACULE .			Nati	ona.	L Cer	nėte	995 ^{DATE} 20c. LOCATION — City or Town, State ry Arlington, Virginia					
	21. SIGNATURE OF FUNERA	O O	2000		00831	RO	ber	D ADDRE	Pumi	phrey	Funer	al E	Iome/		
	M00831 Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501														
	23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest											Approximate			
	ehock, or he IMMEDIATE CAUSE (Fin	eert fallure. I	List only one ceu	ee on eech line	0.						•	•		interval Between Onset and Death	
	disease or condition	-	Cardi	opulmona	ανι Δ	rroc	+							- FACA 194 TIDES	
	resulting in deeth)		DUE TO	(OR AS A CONSE	DUENCE OF):	L							sudden	
Z			Respi	ratory 1	Failu	re								days	
CERTIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A CONSE	DUENCE OF):			-					uays	
8	cause. Enter UNDERLYi CAUSE (Disease or inju		Dehyd	ration (OR AS A CONSE										days	
E 1	thet initiated events		DUE TO	(OR AS A CONSE	DUENCE OF):									
8	resulting in death) LAS	' L.	. Malnu	trition										days	
2	PART ii. Other eignifica	nt condition:	s contributing to	deeth but not r	esulting in	n the un	derivino	Cause	niven in	Pert i 2	4s, WAS AN	MITTORY	246	WERE AUTOPSY FINDINGS	
MEDICAL	Dementia,										PERFOR	MEO?	2.40	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
			2010000	<u>ur 11001</u> (40110					— I	YES 24	NO		OF DEATH?	
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PHYSICIAN:	DID TOBACCO U		CIDUTE TO CA		E OF OEAT			UNC	EKIAII	N KI					
2	EXAMINER?		HOSPITAL:			OTHER	l:								
¥∥	27. MANNER OF DEATH		28a. OATE OF				28c, INJ		sidenca	6 Other (Specily)	HIRV OC	CUBED		
=		Pending	(Month, D	ay, Year)	28b. TIME INJU	JRY M	WO	RK7	¬ NO .	200. DESC	HIDE HOW IN	JUNT OC	COMED		
B	2 Outstand	nvestigation	28e. PLACE O	F INJURY — At ho	me, farm, st	reet, fecto			1,10	281 LOCAT	ION (Street a	ad Number	or Rumi D	nute Mumber	
		Could not be determined	building,	etc. (Specify)			10.				Town, Stete)	no reumber	OF HOVER IN	oute Number,	
COMPLETED	29a. CERTIFIER	EVINO BUILD	MANUTO IN THE	W		1300						_	-		
ΔP			CIAN: To the best of											=.	
One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and piacs, and due to the cause(a) and manner as stated										and manner as stated.					
296. SIGNATULE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)															
ē l	1000	was	- /W	4				D3	2332	2		Ap	ril	14, 1995	
	30, NAME AND ADDRESS OF			•		,									
	Suresh Kuma	r Gupt	a, M.D.	9801 Ge	eorgi	a Av	enue	, Si	lver	r Spri	ng, M	aryl	and	20902	
	31. DATE FILED (Month, Day, 1		REGISTRA	R'S SIGNATURE	all										
	APR 19 1995 Julia Davelson Randall														



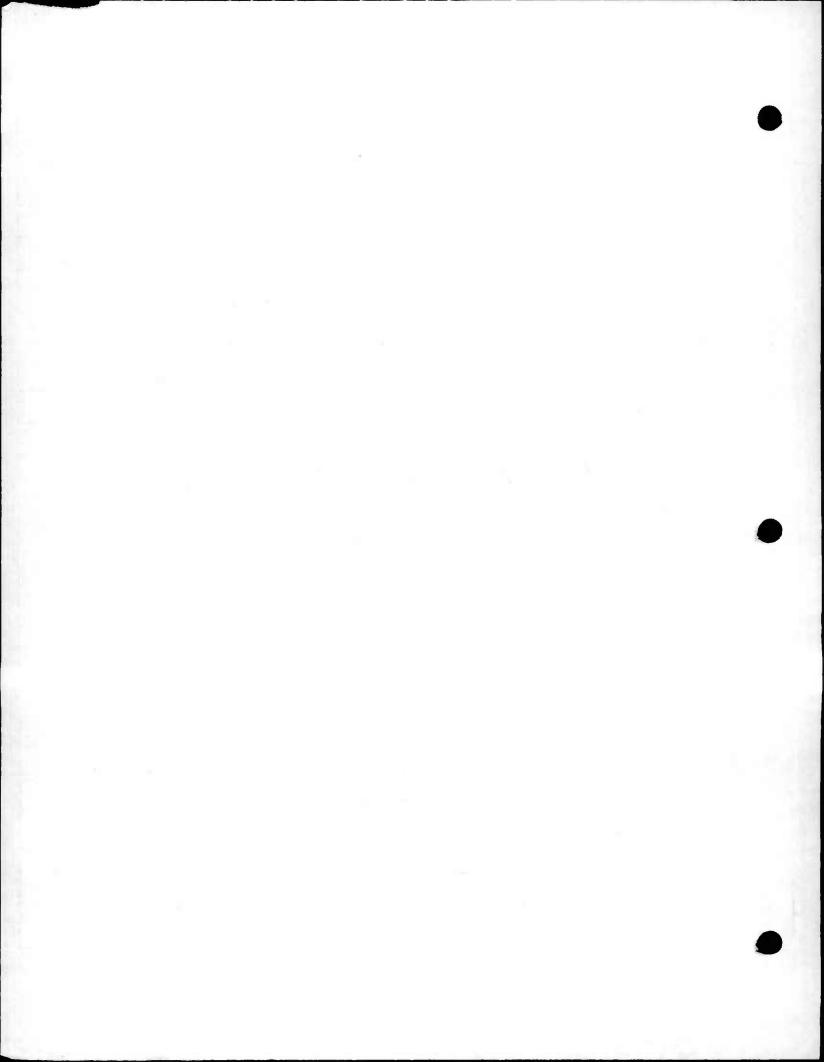
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT, If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

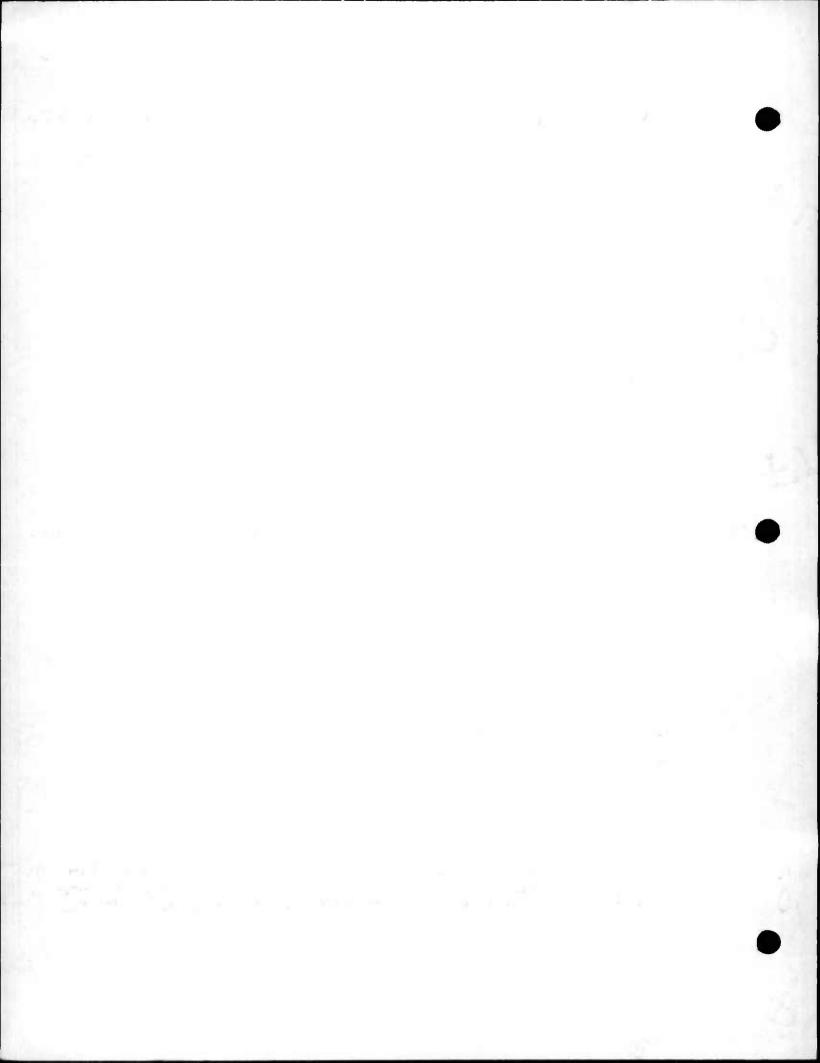
	1 -	REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
į	1, D	ECEDENT'S NAME (First, Middle, Last)		2. DATE O	F DEATH

	1. DECEDENT'S NAME (First	. Middle, Lest)								2. DATE C	E DEATH			A THIS OF BEATH
	ROSAURA	1000	1.0	MARRERO-	RTVE	QΛ				MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	B. AGE (In yrs. las		IF UNDER	4 4540			APRI		, 13	995	2:55 A M
	058-24-686		1 M 2 XF	85	YRS.	MONTHS	DAYS	IF UNDER	MIN.	(Month,	Day, Year)	240	Country	
	90. FACILITY NAME (If not in			60	Tho.						28, 1			to Rico
œ								OR LOCATI		ATH		9c. COU	NTY OF DE	EATH
<u>ō</u>	Washington	Advent	tist Hosp	oital		Ta	ikom	a Pa	rk			Mor	ntgom	ery
S	10e. STATE	10b. COUNTY	,		10c. CITY	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
DIRECTOR	Maryland	Princ	ce George	210	Tak	coma	Don	<u>ا</u>					1	LIMITS?
	10e. STREET AND NUMBER		ic ocorge	, 3	Ide	Collid	_	ZIP COD	F.		_	10a CIT	IZEN OF W	1 X YES 2 NO
FUNERAL	7201 Flower	c Avenu	Je					2091	2					States
3	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. \				IC OBIGINS	(Specify Yes			- American Indian,
	1 Never Married 2 X		FORCES? 1 IF YES, GIVE W	YES 2 XN	10	- 11	yes, sp	ecify Cube	n, Mexice	1, Puerto Ri	can, etc.) Black, Wr			White, etc.
B	3 Widowed 4 Divo						Jerto	to Rican			Specif	White		
COMPLETED	15. DEC	EDENT'S EDUC y highest grade	CATION completed)				ECEDENT'S USUAL OCCUPATION live kind of work done during most of working				CIND OF BUS	INESS/INC	DUSTRY	
9	Elementary/Secondary (0	College (1-4 or 5	life Do MOT use entired to											
A P	6	Tai	lor /	Sea	mst	ress		Cl	othin	g / /	Alter	ations		
8	17. FATHER'S NAME (First, M	errero	18. MOTHER'S NAME (Fit						ddle, Maiden	Sumeme)				
BE	Octaviano		Carmela Rosario											
ē	19a, INFORMANT'S NAME (7	SS (Street end Number or Rural Route Number, City or Town, State, Zip Code)												
-	Benjamin Ri	Benjamin Rivera, Sr. (Son)					n St	treet	t, Ta	akoma	Park	, MD	209	12
	20e. METHOD OF DISPOSIT. 1 X Suriat 2 Crematic		oval from Stata	20b. PLACE A	ND DATE C	P DISPOSI	TION /Na	me of		DATE	20c. LO	CATION -	City or Tov	vn, State
	4 Donation 5 Other			Gate	of He					4-17	7 Silver Spring, MD			
1	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE			Ra	NAME AN	D ADDRE	SS OF FAC	rvi	ces, I	Δ		
- 1	2 off	_15.1	1/1	M	00827						er Spi		MD	20910
	23. PART i. Enter tha di	iseases, Dr C	omplications the	t caused the da	eth. Do n		tha mo	da of dyi	ng, such	ss cardi	c or respi	ratory sri	rest.	Approximate
- 1	snock, or n	aart fallure. (List only one cau	ise on each line								,	,	interval Batween
	iMMEDIATE CAUSE (Fir disease or condition		Smoke i	nhalati	an an	d +b	0.000	.1 4.		0.0				Onset end Death
	resulting in death)			(OR AS A CONSEC			erme	3T TI	ilota	Les				
-				,		,								
CERTIFICATION	Sequentially list condition if any, leading to imme-		DUE TO	(OR AS A CONSEC	UENCE OF	j:								<u> </u>
8 I	cause. Enter UNDERLY	ING												
Ĕ	CAUSE (Disease or inju that initiated events		DUE TO	(OR AS A CONSEC	UENCE OF):								
	resulting in death) LAS	T .	1,											
2		_												
	PART II Other significe	nt condition	annielbutine to	donth hut ant a			4 - 1 - 1 - 1							
S	PART II. Other aignifics	nt condition	contributing to	death but not n	eaulting in	n tha un	dariying	cause (jiven in i	Part I.	4a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL	PART II. Other aignifics	nt condition	contributing to	death but not n	eaulting in	n tha un	dariying	cause (jiven in i			MED?		
MEDICAL									jiven in i		PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	DID TOBACCO U	SE CONTR		USE OF DEA	TH YE	S 🗆 N	10 🛣		given in I	_	PERFOR	MED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
- 1	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S D N	NO L			_	PERFOR	MED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 XYES 2 NO	SE CONTR	RIBUTE TO CA HOSPITAL: 1 □ Inpetient 2 X	USE OF DEAT	TH YE	S N H (Check o	NO k	UNC	ERTAIN	8 Other (PERFOR	meD? □ NO cial)		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH	SE CONTR	HOSPITAL: Inpetient 2 X	USE OF DEA' 26. PLAC 27. PLAC 28. PLAC 28. PLAC 3 INJURY 97. Year)	TH YE	S N H (Check of OTHER 4 Nurs	nnly one) i: ling Home 28c. INJI	UNC	ERTAIN sidence	8 Other (PERFOR	MED? NO Cial)	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!
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BE COMPLETED BY PHYSICIAN: I	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 0 4 Hornicide 299. CERTIFIER (Check only one) 2 X MEDI 290. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF DAVID R. FO 31. DATE FILED (Month, Day,	SE CONTRO D MEDICAL Pending Investigation Could not be determined IFYING PHYSIC CAL EXAMINET OF CERTIFIER F PERSON WHO DWLET, Yeer)	RIBUTE TO CA HOSPITAL: 1 Inpetient 2 X 28a. DATE OF (Month, D. 4-12- 28a. PLACE O building, CIAN: To the best of 6: O COMPLETED CAUS M. D. 32. REGISTRA	26. PLACE 26. PLACE 26. PLACE 26. PLACE 26. PLACE 26. PLACE 26. PLACE 27. PLACE 27. PLACE 28. PL	TH YE E OF DEATH DOA 28b. TIME INJU 2:10 ne, ferm, st eside with occurrent vestigation 27) (Type,	S NH (Check of OTHER 4 Nurse Print) S OTHER 4 Nurse N	ing Home 28c. INJU 1 Yeary, office me, data	UNC 5 Re JRY AT RK7 ES 2 () and place, beth occur 29c. LICE	ERTAIN sidence (NO end due end at the the thinks NUM C.M.E	8 Other (28d. DESC Vict. City or 7201 I to the cause silme, date as	PERFORM (Part Specify) RIBE HOW II im of ION (Street e Town, State) Flower (e) end man	MED? NO CIAL) HOUS HOUS AVE, Der ee stet d due to th	CURED Se fi or Rural Rot Takome ed. He cause(a) E SIGNED (A	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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DHMH-18 Rev 1/89

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL	HYGIENE REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Last)	P WOYNE	MER		S	2. DATE O MONTH	F DEATH DAY	† 43°	3. TIME OF DEATH			
P		4. SOCIAL SECURITY NUMBER 215-52-7171	5. SEX 6. AGE (in yrs. lest birthdey) 46 vrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF NOV.	P BIRTH 1948	Counti	HPLACE (State or Foreign (Y)) hington, DC			
. 2, 3 should	ECTOR	Montgomery Gener	Section Control		96. CITY, TOWN 01ney	OR LOCATION OF D	EATH		ounty of o				
ft. Pages 1,	DIREC	10a. STATE 10b. COUNTY	ce Georges		v, TOWN OR LOCA yattsvil					10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
n. ansit permit.	FRAL	100. STREET AND NUMBER 2010 Rittenhouse	Street		10	01. ZIP CODE 20782		10g. C	USA	WHAT COUNTRY?			
215-0020 attending physician. se as the buriat-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2 🔼 NO	II yes, s	CENDENT OF HISPAI pecify Cuben, Mexico S 2 NO Specif	in, Puarlo Ric		14. RACE — American Indian, Black, White, etc. Specify: White				
22 alor for u	SE COMPLETED	15. OECEDENT'S EGUC (Specify only highest grade of Elemantary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(Give kind of a	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working line. Do NOT use retired.) Painter Pain								
of the be det		17. FATHER'S NAME (First, Middle, Lest) Carroll Merson				16. MOTHER'S NAME (First, Middle, Maiden Surname) Phoebe Davis							
	TO B												
ALLIMOKE, death. Page 6 may by funeral director, page . examiner must be		20a. METHOD OF DISPOSITION 1 \(\text{Sturiel 2 } \) Cremention 3 \(\text{Removal from State} \) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of 4/18/9 BATE completery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, cremetory or other place) 20c. LOCATION — City or Town, campletery, campletery, campletery, campletery, campletery, campletery, campletery, campletery, campletery, campletery, campletery, campletery, cam											
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within 24 mpletely fills cremation,		23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reepiretory arreat, ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition reaulting in death) OUE TO (OR AS A CONSEQUENCE OF):											
S can	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury											
Hygien of	CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):								
that the ded by the th and Me	MEDICAL (PART II. Other significent conditions	contributing to deeth be	ut not reaulting i	in the underlyin	ng ceuse given in		4a. WAS AN AUTOPS PERFORMED?	Y 24b.	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
23 Ge a		DID TOBACCO USE CONTR					V 🗆			1 YES 2 NO			
the se th	SICIAN:	EXAMINER?	HOSPITAL:	26. PLACE OF OEAT	OTHER:	ne 5 🗆 Raeldence	8 Other 6	Spacify)					
The state of	ву рну	27. MANNER OF OEATH Naturel 5 Pending Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	JURY AT ORK? YES 2 NO		PIBE HOW INJURY O	CCUREO				
TTENDI TOR: A after d	ETED I	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, a	street, 1ectory, offic	Co	261. LOCAT City or	ION (Street and Numb Town, State)	er or Rural R	loute Number,			
로 보고 별	COMPL		IAN: To the best of my knowl : On the basis of examination) and manner as stated.			
TO THE HOSPI TO THE FUNER be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Touch		NO	29c. LICENSE NUI	BER 25°	16 P	TE SIGNED	(Month, Day, Year)			
		30. NAME AND ADDRESS OF PERSON WHO 31. DATE FILEO (Month, Day, Year)	1 au sor	-		£ 60 c	Social	ろう	4	ce his			
		APR 18 1995	95 Julia d'auction hardall										



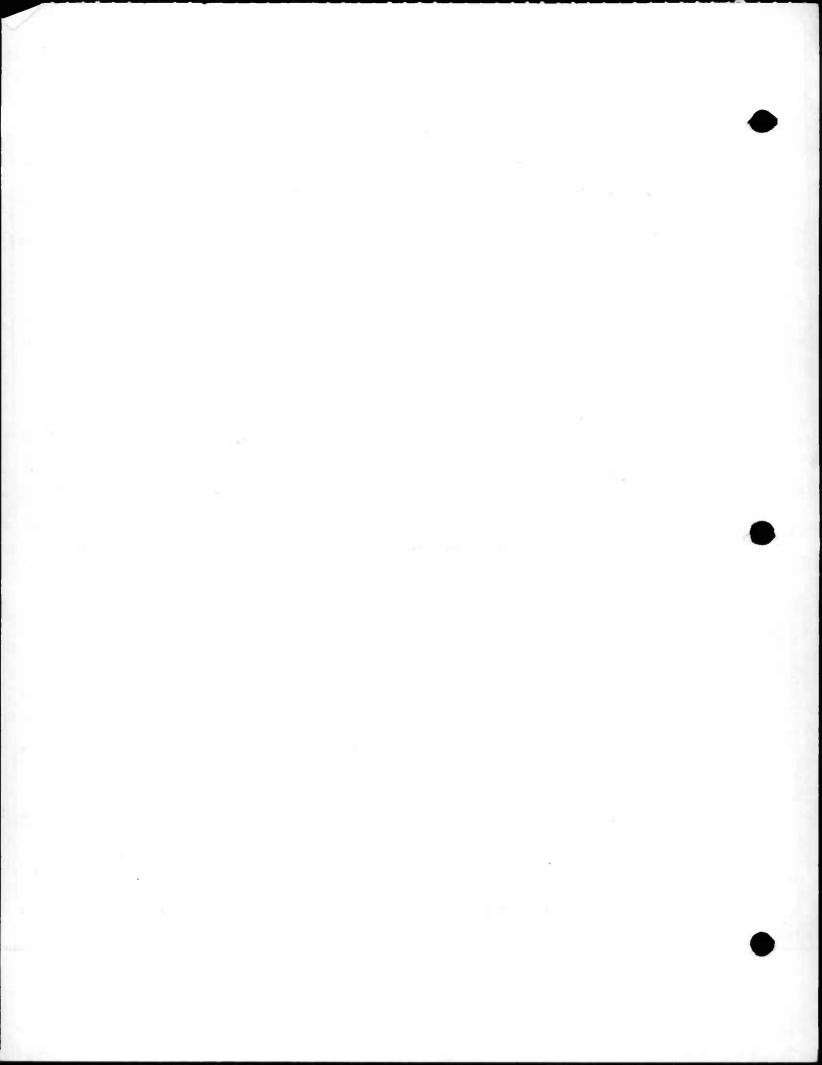
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DIVISION OF VITAL RECORDS,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removed. AND 21215-0020 IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIEN
REGISTRAR	CERTIFICATE OF DEATH	REG. NO

	1 - STATE REGISTRAR	STATE OF MARY	YLAND / CE	DEPAR	TMEN	T OF H	EALTH DEAT	AND	MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)									ATE OF OEATH			3. TIME OF DEATH
9	Edward	Manouel	lian						Ap:	ril 13,	" 1995	YEAR	6:45P M
1 8	4. SOCIAL SECURITY NUMBER		GE (In yrs. last	birthday)	IF UNDER		IF UNDER		7. D	ATE OF BIRTH		S. BIRTH	IPLACE (State or Foreign
	577 32 7554	1 № M 2 🗆 F 6	7	YRS.	MONTHS	DAYS	HOURS	MIN.		fonth, Day, Year) b. 12,19	28	Rhod	w le Island
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	, TOWN	R LOCATIO	ON OF D		~ • == /==		NTY OF D	
OB	2 Duke Court					Rock	vill	е			Мо	ntgo	mery
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN	OR LOCAT	ION						10d, INSIDE CITY
DIRECTOR	Maryland	Montgomery	,]				vill	0					LIMITS?
AL.	10e. STREET AND NUMBER	non ogomery					ZIP CODE		-		10e. CIT	IZEN OF V	VHAT COUNTRY?
FUNERAL	2 Duke Court						2	0850)				States
5	11. MARITAL STATUS	12. WAS DECEDENT EVE			13.	WAS DEC	ENDENT O	F HISPAI	NIC OR	IGIN? (Specify Yes		- American Indian,	
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YE		0		If yes, sp	cify Cubar 2 X NO	n, Mexica	ın, Pue	rto Rican, atc.)		r, White, etc.	
		Korea								White			
I	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - 4 Store Manager 18. DECEDENT'S USUAL OCCUPATION (Ghe kind of work done during most of working life. Do NDT use retired.) Retail Sci 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surm								INESS/IN	DUSTRY			
7									Dotnil	Cole			
OM											25		
O I	Vartan Manoue		Anoush Bogo										
BE	19a. INFORMANT'S NAME (Type/Print)	MAILING	AOORES	S (Street a	nd Number	or Rurai i	Route N	lumber, City or Town	n. State. Zia	Code)			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Str. Lora T. Manouelian 2 Duke Court, Rockville, Maryland									and 2				
	20a. METHOO OF DISPOSITION 1 ☐ Buriel 2 52 Cremetion 3 ☐ Remo	quel from State	20b. PLACE A	ND DATE (OF DISPOS	SITION /Na	me of		1	DATE 20c. LOC			
	4 Donation 5 Other (Specify)		cemetery, cren 10ntgo	mery	ure	matc	rıum	. II	α .	Beth	nesda	, Ma	ryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										D1	. Pumphrey Funeral		
	Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814										0814-3501		
	23. PART I the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
1	IMMEDIATE CAUSE (Final Interval Dath												
	disease or condition resulting in death)	Bladder C	Cancer										15 years
		DUE TO (OR A	S A CONSED	UENCE O	F):								12 years
NO	Sequentially list conditions,	Bone Meta	stase	S									
E	if any, leading to immediate cause. Enter UNDERLYING												
표	CAUSE (Disease or injury that initiated events	c. <u>Metastase</u> DUE TO (OR AS											
CERTIFICATION	resulting in death) LAST	d											
	PART II. Other significant conditions	a contributing to death	hut not re	eultlen i	les ébes sur	do dista		hora la	D: A.I	Tai una iii		1	
CAL	The state of the s	a contributing to death	i but not ra	lauring i	in tha un	idariying	causa g	iven in	Part I	. 24a. WAS AN A		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDI										1 _ YES 2	XXNO		OF DEATH?
Σ	DID TOBACCO USE CONTR	DIRLITE TO CALISE	OF DEAT	'U VE	с П .	10 E	UNIC	EDTAIN					1 TES 2X NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	dibote to CAOSE	28. PLACE				UNC	EKIAII	<u> </u>				
SIC	EXAMINER? 1 YES 2 1 NO	HOSPITAL:			OTHER		• X Pa	idense	400	ther (Specify)			
žΙ	27. MANNER OF DEATH	28a. DATE OF INJUR	IY	28b. TIM	E OF	28c. INJ	JRY AT			DESCRIBE HOW IN	JURY OC	CUREO	
BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	"	INJ	URY M	1 🗌 Y	ES 2	NO					
	3 Suicide 6 Could not be	28s. PLACE OF INJU building, etc. (S)	IRY — At hom	ne, tarm, s	street, tect	ory, office			28t. 1	OCATION (Street a	nd Number	or Rural R	oute Number,
COMPLETED	4 Homicide detarmined									ony or rown, otoroy			
7		CIAN: To the best of my kno											
Š	one) 2 MEOICAL EXAMINE	R: On the beats of examinat	tion and/or in	rvestigatio	n, in my o	pinion, de	ath occur	d at the	time, d	lete and place, and	dua to th	e cause(s	and manner as stated.
w II	296. SIGNATURE AND TITLE OF CERTIFIES						29c. LICE	NSE NUM	ABER		29d. DAT	E SIGNED	(Month, Day, Year)
TO B	1900	v~		-			D35	635			▶ 7	April	14, 1995
-	30. NAME AND ADDRESS OF PERSON WHO												
	Joseph Kaplan, M 31. DATE FILED (Month, Day, Year)			Cen	ter	Driv	e, R	ockv	7il]	le, Mary	land	208	50
	APR 17 1995	Julia davelu											
	<u> </u>	Hama anamari	ormand	ally									



$\overline{}$	1 - STATE REGISTRAR	STATE OF MAN		CATE OF		MENTAL HYGII		
	1. DECEDENT'S NAME (First, Middle, Katherine Ire		Merrev			2. DATE OF DEATH MONTH 4-21-	DAY Y	3. TIME OF DEATH 1545
	4. SOCIAL SECURITY NUMBER 213-05-6123	5. SEX 6. AC	GE (In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year, 4-27-1))	BIRTNPLACE (State or Foreig Country) Pa
TOR	9a. FACILITY NAME (If not institution, Medpointe			96. CITY, TOWN C	R LOCATION OF D Kton	DEATH	9c. COUNTY	of DEATH Cecil
DIRECTOR	RESIDENCE OF DECEDEN 10a. STATE 10b. CC		10c. CITY	TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 109 Locust L	ane		101	ZIP CODE 21921			J.S.A.
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF	ES 2X NO	13. WAS DEC It yes, spe 1 YES	Yes or No— 14.	RACE — American Indian, Black, White, atc. Specify: White		
PLETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	EOUCATION grade completed) College (1-4 or 8+)	16a. DECEOENT'S I (Give kind of w life. Do NOT use Secret	ork done during mo- retired.)	N st of working		BUSINESS/INDUS	TRY
SE COMPL	Ralph Watts Pearce Nellie Porter Reed							
TO B	190. INFORMANT'S NAME (Type/Print) Kaye Irene Me	rrey				Flkton		
	23. PART I. Enter the disease shock, or heart full iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Ca u	A CONSEQUENCE OF				spiratory errest	Approximate interval Better Onset and I
HTIFICATION	Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in deeth) LAST	C. DUE TO (OR A	S A CONSEQUENCE OF	2				20 gen
MEDICAL CERTIFI	if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A DUE TO (OR A DUE TO (OR A	S A CONSEQUENCE OF A CONSEQUENCE OF A LUCE CO	2	ceuse given in	PERI	AN AUTOPSY FORMED? 3 2 NO	24b. WERE AUTOPSY FINE AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO
AN: MEDICAL CERTIFI	If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST PART II. Other eignificant cond 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO	DUE TO (OR A DUE TO (OR A d. Hype	S A CONSEQUENCE OF S A CONSEQUENCE OF 1 + CU S CONSEQUENCE OF	28. PL	ACE OF DEATH (C	PERI 1 YES	FORMED?	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
MEDICAL CERTIFI	If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST PART II. Other eignificant cond	DUE TO (OR A DUE TO (OR A DUE TO (OR A AL HOSPITAL: Inpatient 2 = ER/O Month, Day, Yes	S A CONSEQUENCE OF WELD S A CONSEQUENCE OF LEGGE S A CONSEQUENCE OF LEG	28. PL OTHER: Nursing Hom M 1 1 1	ACE OF DEATH (C 5 S Residence JRY AT RKY ES 2 NO	PERI 1 YES	W INJURY OCCUR	24b. WERE AUTOPSY I AMALABLE PRIOF COMPLETION OF OF DEATH? 1 YES 2

BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. burial-transit ours after death. Page 6 may be retained by the hospital or attending physician. use as the funeral director, page 5 should be detached for notified at pe must medical examiner the signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo the other traumatic event, 6 any Injury, 23 shows this certificate has been with the State Dept. of Item OR ATTENDING PHYSICIAN: 9 28 Is marked, After DIRECTOR: A Item FUNERAL I Ξ HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

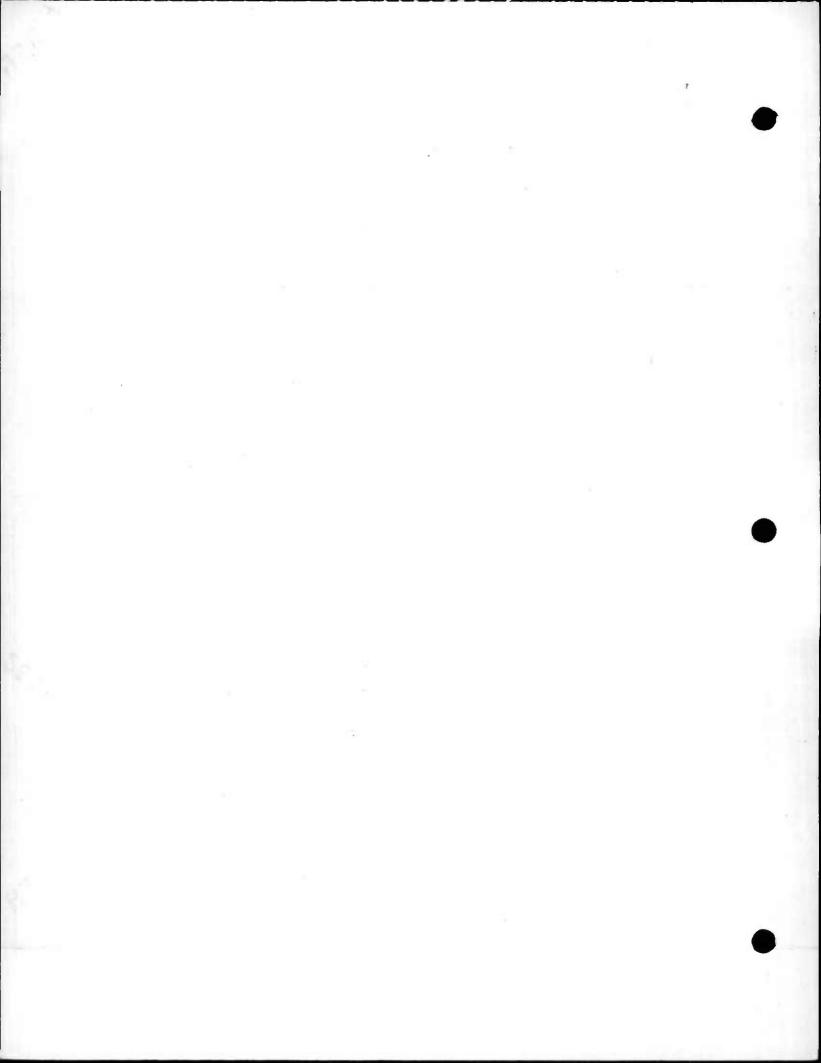
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH O YEAR dell M 5.40 AM Sr. 04 20 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER I YEAR S. BIRTHPLACE (State or Foreign DAYS (Month, Day, Year) 3 1 M 2 F 5 8 HOURS 24 YRS. 40 Winnsboro, SC 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Mechica DIRECTOR Libury Ceci1 Baltimore RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Ceci1 MD Baltimore 1 YES 2 NO FUNERAL 10a STREET AND NUMBER tot. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2501 Violet Ave. Apt905 North 21215 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \boxtimes YES 2 \square NO IF YES, GIVE WAR OR DATES 7-23-196811. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Maxican, Puerto Rican, atc.)
1 ☐ YES 2 ☒ NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced black ETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 servicemen U.S. Navy 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname Samuel Mayfield BE Pearl Evans Mayfield 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 2 2501 Violet Ave Apt.905 Emma Mayfield North Balt.MD 20a. METHOD OF DISPOSITION
15© Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata elary, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ceme. 4-25 Dela. Bear. DE 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY The House of Wright Mortuary Inc. Box 447 Wilm., DE 19899 .0 23. PART i. Enter the diseases, Dr complications that coused the death, DD nDt anter the mode of dying, such as cardiac or respiratory arrast, shock, Dr heart feliure. List only one cause on each line. Approximata intarvai Betwean **IMMEDIATE CAUSE (Final** Onset and Daath disease or condition Canier inc resulting in death) DUE TO OR AS A CONSEQUENCE OF): des me CERTIFICATION Sequantially list conditions, DUE TO OR AS A CONSEDUENCE OF it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 □ Nursing Homa 5 □ Residence 6 □ Other (Specify) 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 1 YES 2 NO В 2 Accident Investigation 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER t XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 1 elnda - 20-0 rung D3016 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JO14413 SITAHLDA Rel 6 (Cernelle 31. DATE FILED (Month, Day, Year) Wastrans Structure Royall

DHMH-16 Rev 1/89

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B. AGE (In yrs. last birthday) 222-07-1178 76 DAYS HOURS 1 XM 2 - F YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) Union Hospital DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Cecil Maryland E1kton permit. FUNERAL 10e. STREET AND NUMBER 223 Hollingsworth Manor attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ntal Hygiene prior to burial, cremation, at returned. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married ВҰ 3 Widowed 4 X Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Jitney Driver 12 17. FATHER'S NAME (First, Middle, Last) Harry McVey Mackie notified at BE 19e. INFORMANT'S NAME (Type/Print) 2 Kenneth M. Mackie pe 20s. METHOD OF OISPOSITION
1 XBurlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Must examiner 21. SIGNATURE OF FUNDAL SERVICE LICENSEE ours after death. medical IMMEDIATE CAUSE (Final the disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, requires that the death certificate be executed with Chantests & Lin traumatic CERTIFICATION Liver Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING Alwholism CAUSE (Disease or Injury or other signed by the attending phy Health and Mental Hygiene OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST shows any injury, MEDICAL DIRECTOR: After this certificate has been hours after death with the State Dept. of Item 28 is marked, or Item 23 sho PHYSICIAN: OR ATTENDING PHYSICIAN: The law r 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 1 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 2Sc. INJURY AT 1 Natural 5 Pending ВҰ Investigation 2 Accident 28e. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be COMPLETED 4 Homicide determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTL be filed within 72 hours at IMPORTANT: If Item 2 29s. CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER BE Jui mi Han MD 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

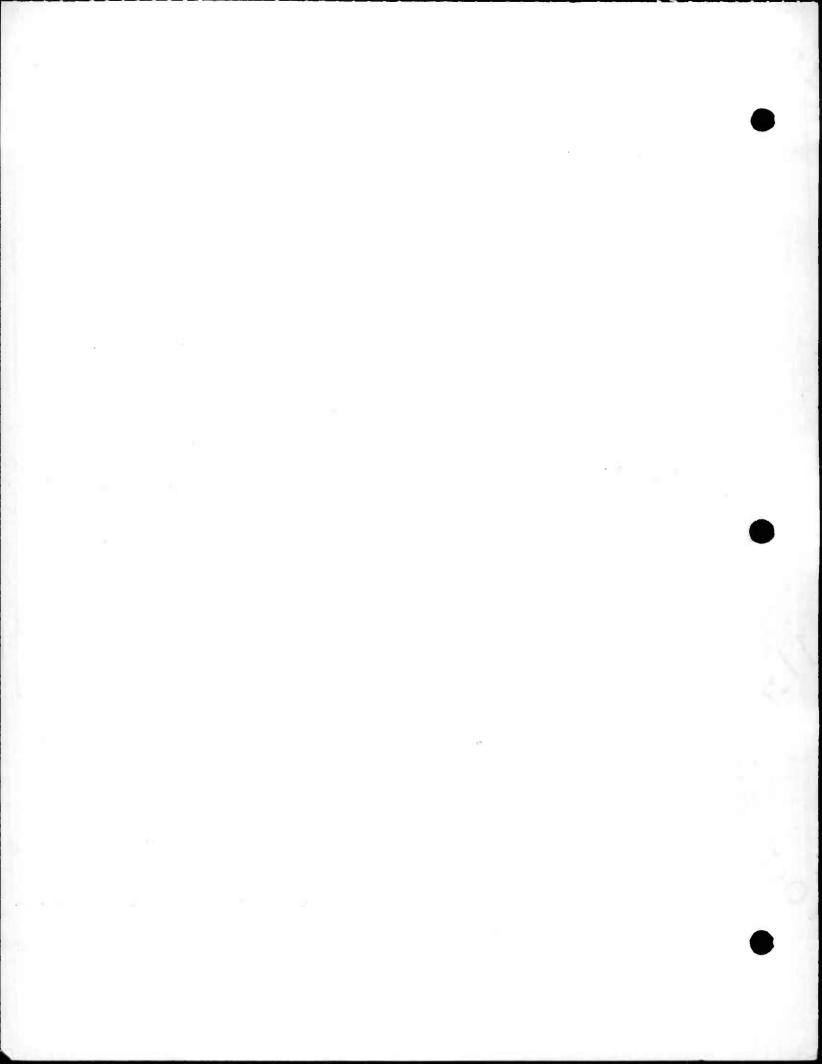
1 - STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Las 2. DATE OF OEATH MONTH 3. TIME OF DEATH Gilbert 4-23-95 0053 4. SOCIAL SECURITY NUMBER 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Menth. 1 1/2 - 1 8 Maryland MIN 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH E1kton Ceci1 10d. INSIDE CITY LIMITS? 1 X YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21921 U.S.A. 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 YES 2 NO Specify Specify: White 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Chrysler Corp. 16. MOTHER'S NAME (First, Middle, Meiden Surneme) Dora Scott 19b. MAILING ADORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1624 Old Elk Neck Rd, Elkton, Md. 21921 OATE 20c. LOCATION - City or Town, State Sharps Cemetery 4/26/95 Fair Hill, Md. 22. NAME AND AGORESS OF FACILITY 259 E. Main St., Gee Funeral Home Elkton, Md. 21921 23. PART I. Enter the diseases, or complifetions that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onset and Death 4 munte. 4 with inti accites PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 4 Nursing Home 5 Residence 6 Other (Specify) 28d. OEŞCRIBE HOW INJURY OCCUREO 1 YES 2 NO 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner es stated. 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, data and placs, end due to the ceuse(s) end mennar as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D04823 ► 4|23|95 Jui Chih HSW MD Wet men st. EKYOL Md 21921 223 APR 25 1995 32. HEGISTRATIS SIGNATURE

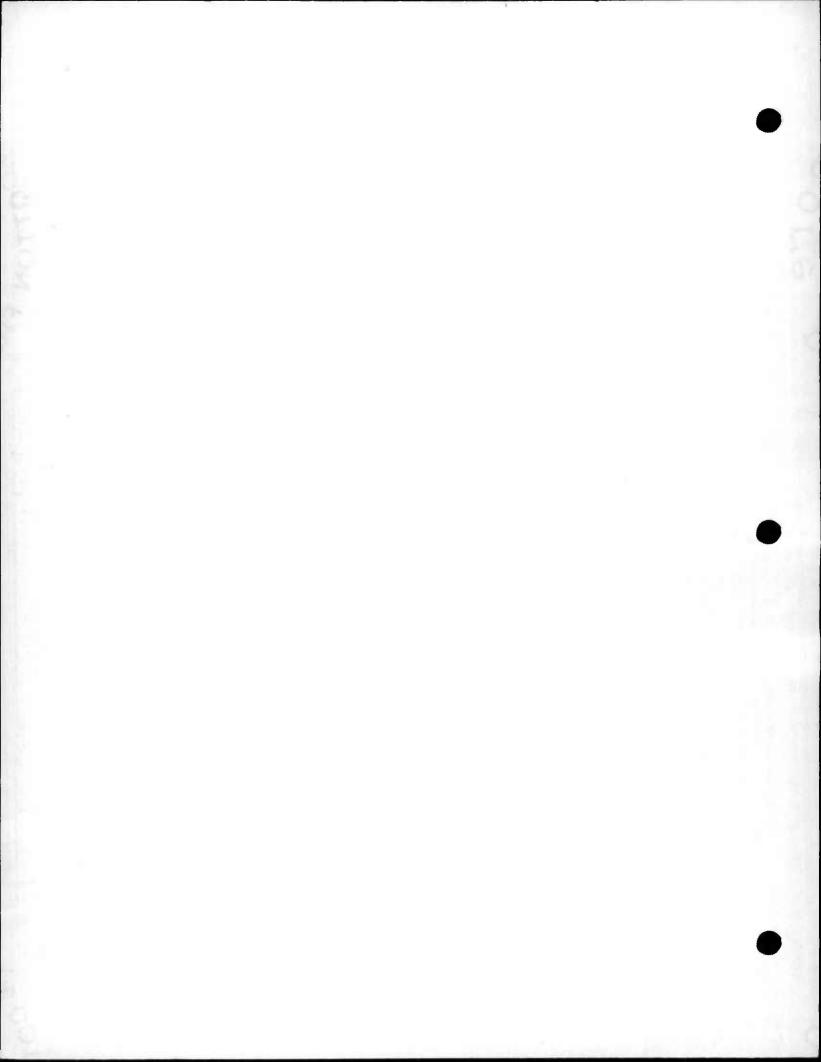
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
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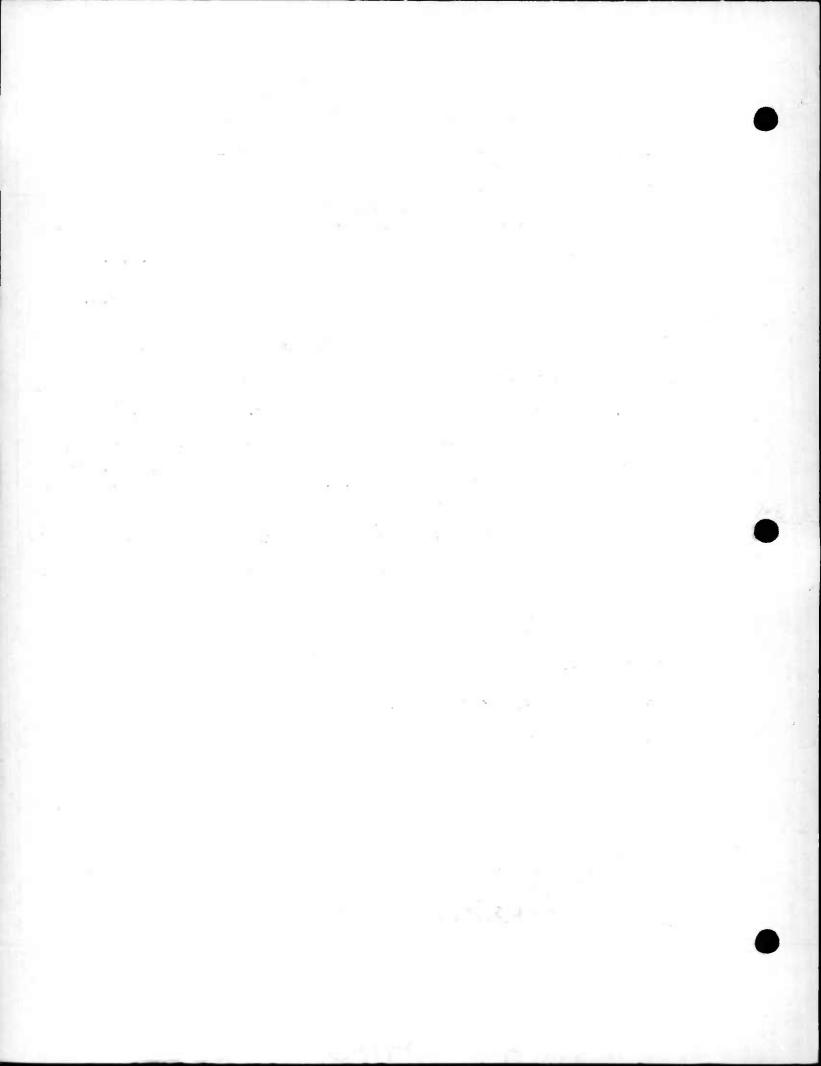
		FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENT	AL HYGIEN REG. NO		1 1	, , , , ,			
		1. DECEDENT'S NAME (First, Middle, Last) B.LOUISE Mejia					2. DAT MON ADY	E OF DEATH		395	1855 M			
pir		4. SOCIAL SECURITY NUMBER 260-07-8051	1 🗌 M 2 🔀 F	n yrs. lest birthdey) 78 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		e OF BIRTH oth, Day, Year)		Political	ACE (State or Foreign bama			
1, 2, 3 should	CTOR	98. FACILITY NAME (If not institution, give st The Kent & Queen / RESIDENCE OF DECEDENT	WOOD COMPANY	tal Inc.		town MD	DEATN		Sc. COUNT Kent	Y OF DEA	TN			
nit. Pages	DIRE	MARYLAND CEC	IL	10c. CIT	Georg	retown					Od. INSIDE CITY LIMITS? YES 2 NO			
burial-transit permit. Pages	UNERAL		erick St.			21930			USA		AT COUNTRY?			
the	BY F	11. MARITAL STATUS 1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yes, s	CENDENT OF HISPA pecify Cuban, Maxic S 2 X NO Spec	an, Puarto	an, Puarto Rican, atc.) Bis			American Indian, White, stc. White			
for use as	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT u		ON ost of working	166. KIND OF BUSINESS/INDUSTRY							
tachec	TO BE COMP	1.7. FATNER'S NAME (First, Middle, Last)		Mach	inist		Metal Equipment Manufacturing IAME (First, Middle, Maiden Surmane)				10			
at de		Unknown				Unkno		Middle, Malden	Sumame)					
5 should notified		19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural		nber, City or Tow	n, State, Zip C	lode)				
be no	۲	William M. Me	jia								MD. 21930			
frector, pa		20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removel from State 4 Donation S Other (Specify) 20b. PLACEAND DATE Of DISPOSITION (Name of cemelory, cremetory or other piece) Capitol Crematory A 19 Dover DE												
he funeral di al. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	γ	5510	Gale	na Fune	eral	Home	Of S	Step	hen L			
the attending physician and completely filled in by the funeral director, page 5 should be detached for Mental Hygiene prior to burial, cremation, or removal. Along the traumatic event, the medical examiner must be notified at once.	RTIFICATION	23. PART T. Enter the diseasea, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ehock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of):												
igned by the att ealth and Menta rs any Injury,	EDICAL C	PART II. Other significent conditions	contributing to deeth bu	ut not resulting	in the underlyin	g cause given in	Part I.	24e. WAS AN PERFOR 1 YES 2	MED?	A) Ci	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
been sign ft, of Healt shows	N: M	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	F DEATH YE	S I NO B	J UNCERTAI	N []			1	YES 2 NO			
cate has t State Dept Item 23	< □	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	8. PLACE OF DEA			•••							
rtificat he Sta or Ite	YSICI	1 VES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpa	itlent 3 🗆 DOA	OTHER: 4 Nursing Non	ne 5 🗆 Realdenca	6 🗆 Oth	er (Specify)						
fter this ce eath with the marked,	ву РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	URY WO	JURY AT ORK? YES 2 NO	28d. DE	SCRIBE HOW II	NJURY OCCU	RED				
after d	ETED	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY - building, etc. (Specif	At home, farm, i	street, tectory, offic			CATION (Street a or Town, State)	and Number or	Rural Rou	le Number,			
TO THE FUNERAL DIRE be filed within 72 hours IMPORTANT: If Item	COMPL	2 MEDICAL EXAMINER	IAN: To the best of my knowle : On the basis of examination								nd manner as stated.			
TO THE be filed v	TO BE		rue			29c. LICENSE NU 138			29d. DATE S	18-5	onth, Day, Year)			
	-	John C. Seymour MD. 120 Speer Rd. Chestertown, MD. 21620 31. Date Filed (Month, Day, Near) APR 21 1995												
1		111 11 10 22	A											



FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR				OFILL III	ICATE	OF	DEA	111		HEG. NO.				
	1. DECEDENT'S NAME (First, A	Aiddle, Last)	Nellie	Catl	nerine	М	ull	in		2. DATE OF MONTH	DEATH DA	7 79	YEAR 05	3. TIME OF DEATN 8:20 Pm	
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs.	inst hirthday)	IF UNDER 1	VEAR	IF UNDER	24 MDD	7. DATE OF		,/		HPLACE (State or Foreign	
	214-09-854		1 🗆 M 2 🕇 F	83			DAYS	HOURS	MIN.	(Month, 0	24-1	911	Count	ryland.	
- 3	9a. FACILITY NAME (If not insti	itution, give si	treet and number)			9b. CITY, 1	TOWN (OR LOCATI	ON OF DE	EATN		9c. COUNTY OF DEATN			
DIRECTOR	Frederick	Memo	rial Ho	spita	.1	Fr	ed	erio	k			F	rede	rick	
낊		10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCAT	TION						10d, INSIDE CITY	
PIG	Maryland	Fre	derick		We	oodst	or	0						LIMITS?	
AL	10e. STREET AND NUMBER						10f. ZIP CODE			10g. CITIZE			IZEN OF	N OF WHAT COUNTRY?	
FUNERAL	10122 Wood	sbor	o Road			21798				U.S.					
5	11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO							NIC ORIGIN? (Specify Yes or No-			14. RAC	E — American Indian, k, Whila, atc.	
B	1 Never Married 2 🕅 M 3 Widowed 4 Divorce		IF YES, GIVE V		Mio							hite			
	15. DECEE (Specify only h	DENT'S EDUC	CATION completed)	16a.	DECEDENT'S	USUAL OCC	UPATIO	ON set of working	20	18b, K	IND OF BUS	SINESS/IN	DUSTRY		
COMPLETED	Elamentary/Secondary (0-12		ve kind of work done during most of working Do NOT use retired.												
M P	17. FATNER'S NAME (First, Midd	pecia	pecial Education Aide							1001					
8		,	Dawans							ME (First, Mid			ina Dalaan		
Oliver Clinton Bowers Mary Emma Catherine Bak 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									Baker						
2	Mary A. Parsons													D 21798	
	20a. METNOD OF DISPOSITION			20h PL A	CEANDDATE				3 110		20c. LO				
	4 Donation 5 Other (S	Specify)		Ros	e Hi	ther place)	,		1-13	95	C	lear	r Sp	ring. MD	
	21. SIGNATURE OF FUNETIAL	177	SHEET //			Thompson Funeral Home, Inc.									
	1/10/20	111/	Mu		-	_ P.	0.	Box	31	0 C1	ear	Spr:	ing,	MD 21722	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between														
	IMMEDIATE CAUSE (Final											Onset and Daath			
	disease or condition resulting in death)		DUE TO	rebru	Vale	160		200	1 0/4	ent				3 WKJ	
		_	DUE TO	(OR AS A CON	SEQUENCE O	F) _I		1:	37	1.	1	/		(3)	
CERTIFICATION	Sequantially list condition if any, leading to immedia	na,	DUE TO	(OR AS A CON	SEOUENCE O	f):	Or	ALL V	616	116	(1112	an		1 70	
CA	cause, Entar UNDERLYING CAUSE (Disease or injury	G	n												
田	that initiated evanta resulting in death) LAST		DUE TO	(OR AS A CON	SEQUENCE O	F):									
Ä	resolding in death, EAST		1												
٦	PART II. Other significant	condition	s contributing to	daath but no	ot reaulting	In the und	arlying	g cause (givan in	Part I. 2	Ia. WAS AN		248	. WERE AUTOPSY FINDINGS	
EDICAL	prour	nonia								Ι,	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEC	/											100		OF DEATH? 1 YES 2 NO	
	DID TOBACCO	USE	CONTRIBUT	E TO CA	USE O	F DEAT	н '	YES [7 NO	ाष्ट्र					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?						26. PL			eck only one)					
Sic	1 TES 2 NO		HOSPITAL:	ER/Outpstient	3 DOA	OTHER:		e 5 □ Re	aldence	6 🗆 Other (S	Specify)				
E	27. MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIM	E OF 2		URY AT		28d. DESCF	IBE NOW I	NJURY OC	CURED		
В	Natural 5 Pe	ending vestigation				М		YES 2	NO						
		ould not be termined	28a, PLACE O building,	F INJURY — At atc. (Specify)	home, tarm,	strant, factor	y, offic			281. LOCATI City or	DN (Street a Town, State)	and Numbe	r or Rural	Route Number,	
COMPLETED	29a. CERTIFIER	VINC PI	DIAM. T					atty electron				research and	-		
MP			CIAN: To the best of											a) and manner as stated.	
	29b. SIGNATURE AND LITUE					, opi					- prese, dit				
B	///	241 ()	P. 111					29c. LICI	ENSE NUI	MBER D		29d. DA1	E SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF F	PERSON WN	O COMPLETED CAU	SE OF DEATH (TEM 27) (Type	, Print)		U.	2/01	1			1/11	171	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1G P
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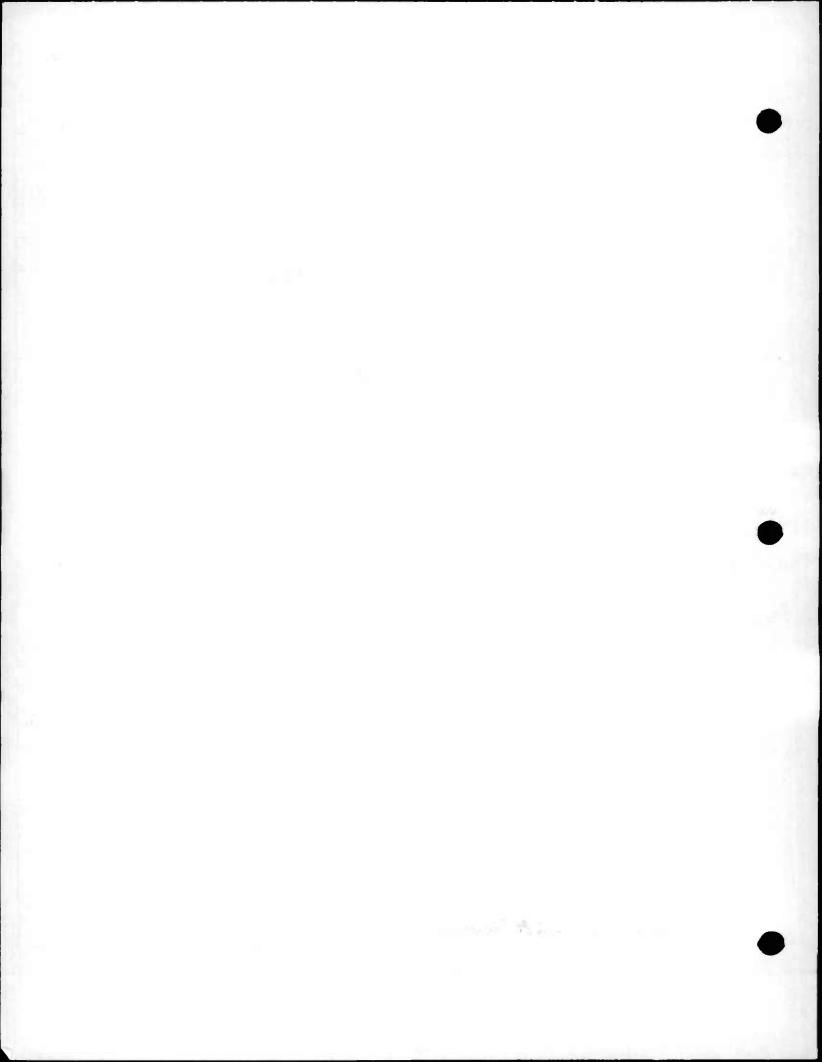
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)	N. La	2. DATE OF OEATH DAY YEAR	3. TIM

	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH		3. TIME OF DEATH
	Albert Hartin Moats			April 10 1901 0306 AM			
		GE (In yrs. lest birtho	lay) IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	- / (BIRTNPLACE (State or Foreign
	219-12-0964 1X M 2 🗆 F	67 YR	S, MONTHS DA	YS HOURS MIN.	Sept. 11		Country)
	9e. FACILITY NAME (If not institution, give street end number)		9b. CITY, TO	WN OR LOCATION OF I			Y OF DEATH
OR	Washington County Hospital			lagerstown		1 0 3	shing ton
ᇈ	RESIDENCE OF DECEDENT					00	-110119
<u>E</u>			CITY, TOWN OR L				10d. INSIDE CITY LIMITS?
	Maryland Washington		Williams				1 TES 2 NO
FUNERAL DIRECTOR	10s. STREET AND NUMBER 10s. CITIZEN O			N OF WHAT COUNTRY?			
2	1-F Milestone Garden Apartments			21795		U.S.A.	
	1 Never Married 2 V Married FORCES? 1 YES 2 NO		If yes	13. WAS DECENOENT OF HISPANIC ORIGIN? (Spe If yes, specify Cuben, Maxicen, Puerto Ricen,		y Yes or No— 14. RACE — American Indian, Black, Whita, etc.	
B	3 Wildowed 4 Divorced W.W. II	R DATES	10	YES 2 X NO Spec	fy:		Specify:
	15. DECEOENT'S EDUCATION	18a. DECEOEN	IT'S USUAL OCCU	PATION	18b. KIND OF BUS	INESS/INDUS	White
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind life. Do NO	I of work done durin OT use retired.)	g most of working			
린	8	Fork	Lift Ope	rator	Auto Mar	ufact	urer
Ö	17. FATNER'S NAME (First, Middle, Last)				AME (First, Middle, Maiden		
BE C	Luther Moats			Anna	Kline		
TO B	19e. INFORMANT'S NAME (Type/Print)	Route Number, City or Town	n, State, Zip Co	ode)			
F	rt, Md. 21795						
20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State							
	4 Donetion 5 Other (Specify)	Greenla	wn Memor	ial Park	4-22-95 Wi	11iam	sport, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home							
	> Scott ////un	nuch					wn, Md. 21740
	23. PART i. Enter the diseases, or complications that cau	eed the deeth. D	o not enter the	mode of dving, au	h ea cerdiec or reepi	ratory erree	t, Approximate
- 1	anock, or neert feiture. Liet only one cause of	n each line.					Interval Between
	iMMEDIATE CAUSE (Final disease or condition	1.31	4	(1)	1		Onaet and Death
	resulting in death) a. DUE TO (OR A	S A CONSEQUENC	E OF): White	OA NAV			
z	En.	of Sita	110	Shich Onaet and Death To proting Cardiny Jys			
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	S A CONSEQUENCE	EOF):		and die	1	7
2	cause. Enter UNDERLYING CAUSE (Disease or Injury						
	that initiated events OUE TO (OR A	S A CONSEQUENCE	E OF):				
H	resulting in death) LAST						
	PART ii. Other eignificant conditions contributing to deet	h but not recuitle	ng in the under	ving ceuse given ir	Part i. 24s. WAS AN	MITTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL			3.00 50020	,,,,,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 🗆 YES 2	□ NO	DF DEATH?
- 11	DID TORACCO LISE CONTRIBUTE TO CALISE	OF DEATH	VES TI NO	☐ LINICEDTAL			1 YES 2 NO
₹ I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)						
Sic	EXAMINER? 1 YES 2 NO						
PHYSICIAN:		2Y 28h		INJURY AT	28d. DESCRIBE HOW II	LIURY OCCUR	260
0 11	27. MANNER OF DEATH 28e. DATE OF INJUR	(r)	INJURY	WORK?			11.5
_	1 Natural 5 Pending (Month, Day, Yea						
à	1 Netural 5 Pending (Month, Day, Yea 2 Accident Investigation 3 Suicide 28a. PLACE OF INJU	JRY — At home, far	m, atreet, factory,	office	281. LOCATION (Street a	nd Number or	Rural Route Number
à	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Yes	JRY — At home, far Specify)	m, atreet, factory,	office	281. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,
à	Netural 5 Pending (Month, Day, Yee 2 Accident Investigation 3 Suicide 8 Could not be determined 28a. PLACE OF INJUDENT Duiliding, stc. (S	ореспу)			City or Town, Stete)		
à	Natural 5 Pending (Month, Day, Yee 2 Accident 1 September 28a. PLACE OF INJ. building, atc. (September 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my known 1 CERTIFYING Control 1 CERTIFYING CERTIFYING Control 1 CERTIFYING	nowledge, death occ	curred at the time,	date end place, and du	City or Town, Stete) I to the cause(e) end men	ner en stated.	
COMPLETED BY	Natural S Pending (Month, Day, Yea	nowledge, death occ	curred at the time,	date end place, and du	city or Town, State) I to the cause(e) end men of time, date and place, end	ner ex stated.	euse(a) and manner as stated.
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E COMPLETED BY	Natural 5 Pending (Month, Day, Yea 2 Accident 3 Suicide 8 Could not be determined 28a. PLACE OF INJ. building, stc. (State of the control of the determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examine 29b. SIGNATURE AND TITLE OF CERTIFIER CAY	nowledge, death occurrently	surred at the time,	date end place, and du	city or Town, State) I to the cause(e) end men of time, date and place, end	ner ex stated.	reuse(a) and manner as stated.
BE COMPLETED BY	Natural 5 Pending (Month, Day, Yee 2 Accident 3 Suicide 8 Could not be 28a. PLACE OF INJ. building, stc. (3 building, stc. (4 Check only one) 2 MEOICAL EXAMINER: On the best of my known one) 2 MEOICAL EXAMINER: On the best of examinating the country of the best of the b	nowledge, death occurrently	surred at the time,	date end place, and du	city or Town, State) I to the cause(e) end men offme, date and place, end	ner ex stated.	reuse(a) and manner as stated.
BE COMPLETED BY	Natural 5 Pending (Month, Day, Yea 2 Accident 3 Suicide 8 Could not be determined 28a. PLACE OF INJ. building, stc. (State of the control of the determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examine 29b. SIGNATURE AND TITLE OF CERTIFIER CAY	nowledge, death occurring and/or investig	surred at the time,	date end place, and du	city or Town, State) I to the cause(e) end men offme, date and place, end	ner ex stated.	euse(a) and manner as stated.



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hodrs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND	/ DEPARTM	MENT OF H	EALTH AND N	MENTAL HYGIE		,			
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH			3. TIME OF DEATH		
	ANNABELLE CATHERINE MOOR	E			April 16, 1995 5:00 (
		Worden a street a street as the street as th						IPLACE (State or Foreign		
	1. 1.									
_	9a. FACILITY NAME (If not institution, give street end number)	96	CITY, TOWN O	R LOCATION OF DE			JNTY OF D	yland PEATH		
<u>6</u>	532 West Howard Street	1	Hagerst	own		Wash	ningt	on		
Si C	10a. STATE 10b. COUNTY	10c. CITY, TO	OWN OR LOCAT	ION				10d. INSIDE CITY		
뚭	Maryland Washington		erstown					LIMITS?		
A	10s. STREET AND NUMBER	101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL DIRECTOR	1548 Mt. Aetna Road			21742		U.	S.A.			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED	13. WAS DECI	ENDENT OF HISPANI	C ORIGIN? (Specify Y		14. RACE	E — American Indian.		
ВУ	1 ☐ Never Merried 2 ☐ Merried FORCES? 1 ☐ YES 2 ₹ IF YES, GIVE WAR OR DATES	ZINO		2 X NO Specify:	, Puerto Rican, etc.)		Speci	k, White, etc.		
0		DECEMBER 1101						White		
COMPLETED	(Specify only highest grade completed)	DECEDENT'S USL (Give kind of work life. Do NOT use re	JAL OCCUPATIO done during mos tired.)	N at of working	16b. KIND OF B	JSINESS/IN	DUSTRY	1		
PL		Bookkeer			Dairy	Indu	ıst.rv			
O.	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAM	IE (First, Middle, Malde					
BE C	John Edward Alter			Lottie		idge				
5 B	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADI	DRESS (Street ar		oute Number, City or To		p Code)			
F	E. Ann Swope	1548 Mt	t. Aetn	a Road H	agerstown	, Mar	ylan	d 21742		
	20e. METHOD OF DISPOSITION 1 № Burlel 2 □ Cremellon 3 □ Removal Irom State 20b. PLAC	EAND DATE OF D	ISPOSITION (Ner	me of	DATE 20c. L	OCATION —	City or To	wn, Slate		
	4 Donation 6 Other (Specify)	Paul's C	Cemeter	y 4–19–1	995 C1	ear S	prin	g, Maryland		
1.0	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			D ADDRESS OF FAC		1 Uom	20			
	Loudo A Lien		1331 E	astern B	ry Funera lvd. Nort	h Hao	erst.	own, Md.		
	23. PART I. Enter the diseases, or complications that claused the shock, or heart failure. List only one cause on each if	deeth. Do not o	enter the mod	fe of dying, such	es cerdlec or res	oiratory er	reet,	Approximeta		
	IMMEDIATE CAUSE (Final	* /	1.	1 7	A 1			Intervel Between Onset end Death		
	disease or condition a. Acute	(1/0C0	endice	1 th	farati	n		10 muster		
	DUE TO OR AS A CONS	SEOUENCE OFY	9	Aueas				(0		
ON	Sequentially list conditions, Due to (or as a cons	The ease (O) years								
Ä	cause. Enter UNDERLYING	,								
Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONS	BEOUENCE OF):								
CERTIFICATION	resulting in death) LAST									
	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS									
CAL			,		PERFO	RMED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDI					1 _ YES	2 NO		OF DEATH?		
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES	ПопП	UNCERTAIN				1 WES 2 NO		
X	25. WAS CASE REFERRED TO MEDICAL 28. PL	ACE OF DEATH (C		OTTOLKIMIT						
Sic	EXAMINER? 1 YES 2 AND HOSPITAL: 1 Inpatient 2 ER/Outpatient		HER: Nursing Home	5 Residence 6	Ther (Specify)	eve gi	pui	Hu		
PHYSICIAN:	27. MANNER OF DEATH 260. DATE OF INJURY (Month, Day, Year)	26b. TIME OF		RY AT	26d. DESCRIBE HOW	- I	- 0	- Jones		
BY	1 Natural 5 Pending (Montal, Day, Fear) 2 Accident Investigation			ES 2 NO						
8	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street	t, lactory, office		281. LOCATION (Street City or Town, State	and Number	or Rural R	loute Number,		
E										
절	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge,									
COMPLET	WEDICAL EXAMINER: On the basis of examination end/o	or investigation, in	my opinion, de	ath occured at the H	me, date end place, a	nd dua to It	te ceuse(e)) end manner ee stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1 Plan		29c. LICENSE NUME	BER	29d. DAT	E SINNED	(Month, Day, Year)		
6	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I)	or 1 1/1	eum	1004	3,59	14	1/7	195		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	Prime Prime	Aac	Ave	Non	21/15	/12.	M M D		
	31. DATE FILED (Morith, Day, Year) APR 1 8 1995	Red 11			,,,,,	4	000	FCMA		
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I OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATTENDING PHYSICIAN: The law requires that the death certificate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 324 PM RALPH WILLIS MOORE Apri 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. & BIRTHPI ACE (State or Food JULY 14, 1913 PENNSYLVANIA 173-03-0351 1 X M 2 F 81 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? HAGERSTOWN MARYLAND WASHINGTON 1 XYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21742 U.S.A. 1420 HAMILTON BLVD. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ₽ 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 ELECTRICIAL ENGINEER BLAST CLEANING EQUIP. 4 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) MINNIE MAE notified at RALPH WILLIS MOORE KING B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1420 HAMILTON BLVD., HAGERSTOWN, MD. 21742 ELIZABETH M. MOORE pe 20a. METHOD OF DISPOSITION
1 Burlel 2 X Cremation 3 Re
4 Donation 5 Other (Specify) 20c. LOCATION -- City or Town, State DATE must SMITHSBURG CREMATORIUM 04-13-95 HAGERSTOWN, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM STREET, HAGERSTOWN, MD. 21740 R. hoel medical 23. PART I. Enter the diseases, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retwe IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition resulting in death) DUE TO (OR AG) CONSEQUENCE OF): event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, 0 if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): the attending p resulting in daeth) LAST 9 PART II. Other significant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? by t shows any signed Health a 1 ☐ YES 2 ☐ NO 1 YES 2 NO been t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State HOSPITAL: OTHER: 1 YES 2 1 NO Inpetient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 9 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this 1 | Natural 5 Pending В 1 YES 2 NO After 2 Accident 28s. PLACE OF INJURY -- At home, ferm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .69 COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined 29a. CERTIFIER 1 ___CENTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as steted. TO THE HOSPITAL O
TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Muchalle 02145 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AHERD -12821-OAKHIL MA IN MOISTRAGE SIGNATURE

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM			MENTAL	HYGIENE REG. NO.				
	1. DECEOENT'S NAME (First, Middle, Lest) Mary Geneva MENTZI					2. DATE (of DEATH	1995 YEAR	3. TIME OF DEATH		
	220-05-6634	6. AGE (In yrs.	- "	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Month, Dav. Year) Gountry			HPLACE (State or Foreign try) yland		
TOR	9a. FACILITY NAME (If not institution, give atree 55 S. Potomac St., RESIDENCE OF DECEMENT	r stown	EATH	5	Washi						
FUNERAL DIRECTOR	Maryland Washir	ngton		10c. CITY, TOWH OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO			
NERAL	10e. STREET AND NUMBER 55 S. Potomac Stre			10f. ZIP CODE 21740				USA	WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U.S., FORCES? 1 ☐ YES 2½ IF YES, GIVE WAR OR DATES	ARMED NO	If yes, sp	ENDENT OF HISPA Holfy Cuban, Maxica 2 NO Specif	an, Puarto Ri	(Specity Yea or ican, atc.)	Spe	E - American Indian, ck, White, atc. city: 7hite		
COMPLETED		mpleted) College (1-4 or 5+)	DECEDENT'S USI (Give kind of work the Do NOT use re homema	done during mo- tired.)	N st of working	16b.	KIND OF BUSIN				
OME	17. FATHER'S NAME (First, Middle, Lest)	0	пошеша	Kel	18. MOTHER'S NA	ME /Fine A4		n home			
	John Wesley Bowmar	1				Seib		mame)			
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural	Route Numbe	er, City or Town, S	State, Zip Code)			
۲	Jean Marquiss		620 Sa	lem Ave	e., Hage	rstow	n, Mary	land 2	1740		
	20a. METHOD OF OISPOSITION 1 M Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-22-95 Hagerstown, Maryland										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY MINNICH FUNERAL HOME										
	OCHTI!	Vennech		415 E.	Wilson	Blvd	., Hage	erstown	, Md.21740		
	23. PART i. Enter the diseesea, or conahock, or heert feliure. Lis iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Chronic rena	ne. 11 failu					Dry arrest,	Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):										
	reaulting in deeth) LAST	reaulting in deeth) LAST									
MEDICAL	PART II. Other algorificent conditions of	contributing to deeth but not	resulting in t	he underlying	ceuse given in		PERFORME 1 YES 2	D?	D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Ž Z	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF DE	ATH YES	□ NO □	UNCERTAIL				1 NES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL/	ACE OF DEATH (
YSI	1 TYES 2 1 NO 1	□ Inpetient 2 □ ER/Outpetient	3 DOA 4		5 Presidence	6 🗆 Other	(Specify)				
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	WOI		28d. OESC	RIBE HOW INJU	RY OCCURED			
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	26d. PLACE OF INJURY — At I building, etc. (Specify)	nome, tarm, stree	t, tactory, office		261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED		N: To the best of my knowledge, on the basis of examination and/o							e) and menner as stated.		
BEC	296. SIGNATURE AND TITLE OF CONTINUE	1920 1929	2 Ox		29c. LICENSE NUM		29	d. DATE SIGNE	(Month, Day, Yeer)		
<u></u>	early Ano	neer /	112		DIII3	33		4-	21-95		
	Charles C. Spenc	ompleted cause of oeath (it er, M.D., 1198	EM 27) (Type, Prin	Ave.,	Hagersto	own, N	id. 217	40			
	31. DATE FILED (Month, Day, Year) 2 1 1895	32 GEGISTRAR'S SIGNATURE	M								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 B BALTIMORE, MARYLAND 2	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the
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ID 21215-0020 ospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The I

		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	IEALTH AND M	ENTAL HYGIENE	E		
		1. DECEDENT'S NAME (First, Middle, La David	Theodor	e M	McKEE		2. DATE OF DEATH MONTH LOS	95 YEAR	3. TIME OF DEATH	
pin		4. SOCIAL SECURITY NUMBER 212-14-6542 90. FACILITY NAME (If not institution, gi	1⊠M2□F 7	(In yrs. lest birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) Jan.16,192	20 Ma	ryland	
1, 2, 3 should	TOR	Washington Cour	nty Hospital			agerstown		WASHIN		
nit. Pages	FUNERAL DIRECTOR		ashington		y, town on Locat lear Spr				10d. thSIDE CITY LIMITS? 1 YES 2 NO	
the burial-transit permit. Pages		15620 Broadfo				21722		USA	WHAT COUNTRY?	
s the burial-t	BY	11. MARITAL STATUS 1 Never Married 2 M Merried 3 Widowed 4 Divorced	ed 12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		If yes, sp	ENDENT OF HISPANK ecify Cuben, Mexican, 2 NO Specify:	C ORIGIN? (Specify Yes Puerto Rican, etc.)		E — American Indian, ck, White, atc. city: White	
ed for use a	COMPLETED	15. DECEDENT'S 8 (Specify only highest gi		npleted) (Give kind of work done during in		ing most of working				
be detache		17. FATHER'S NAME (First, Middle, Last) David	(NMI)	McKee			E (First, Middle, Meiden S	Surnama)	Chaney	
5 should t	TO BE	19a. INFORMANT'S NAME (Type/Print) Bernice K. McKee	VINELL 7	19b. MAILING	AODRESS (Street s	nd Number or Rural Ro	ute Number, City or Town Clear Sp	, State, Zip Code)	•	
ctor, page nust be		20s. METHOO OF DISPOSITION 1 Burlat 2 Cremation 3 R 4 Donation 6 Other (Specify)	Removal from State 20t	D. PLACEAND DATE O	OF DISPOSITION (Na	me of	OATE 20c, LOC	CATION — City or T	own, Slats	
filled in by the funeral director, page 5 should be detached for use as on, or removal. The medical examiner must be notified at once.		Pinesburg Mennonite Cem. 4/25/95 Williamsport, MD 2179 22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795								
completely filled in by tall cremation, or remover event, the medical		23. PART I. Enter the diseases, ahock, or heart failured immediate CAUSE (Finsi disease or condition resulting in death)	re. List only one ceuse on e	each line.			ARRES	7	Approximate Interval Between Onaet and Death	
ending physician and of Hygiene prior to buri- or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST	- POLIM	CONSEQUENCE OF	FAEL	1A DISEAG				
shows any	MEDICAL	PART II. Other significent condit	ATTOMON NTRIBUTE TO CAUSE O	DF DEATH YE	SA/E (CANCER	24e. WAS AN A PERFORM	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:	e 5 🗆 Residencs 6	Other (Specify)			
eath with t marked,	ву рн	27. MANNER OF DEATH 1 Natural 5 Panding 2 Accident Investigation			WO 1 N	RK? 'ES 2 NO	28d. OESCRIBE HOW IN	JURY OCCURED		
RECTOR: A		3 Suicide 6 Could not 4 Promittee determined		— At home, ferm, s	treel, factory, office		28f. LOCATION (Street en City or Town, State)	nd Number or Rural	Route Number,	
FUNERAL DIRECT WITHIN 72 HOURS	COMPLETED		IVS CIAN: To the best of my know						s) and manner as stated.	
TO THE FUNERAL be filed within 72 IMPORTANT: If	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFICATION OF CERTIFICATIO	WIDS, MA			29c. LICENSE NUMB	ER	≥ 4/2/	(Month, Day, Mar)	
	۴	30. NAME AND ADDRESS OF PERSON	HO COMPLETED CAUSE OF DE		Print)	L. 2179	73	/	/	
		APR 2 4 1995 J	22, REGISTRAT'S SIGN	ATURE						

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L RECORDS, P.O. BOX 68/60,	law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospita

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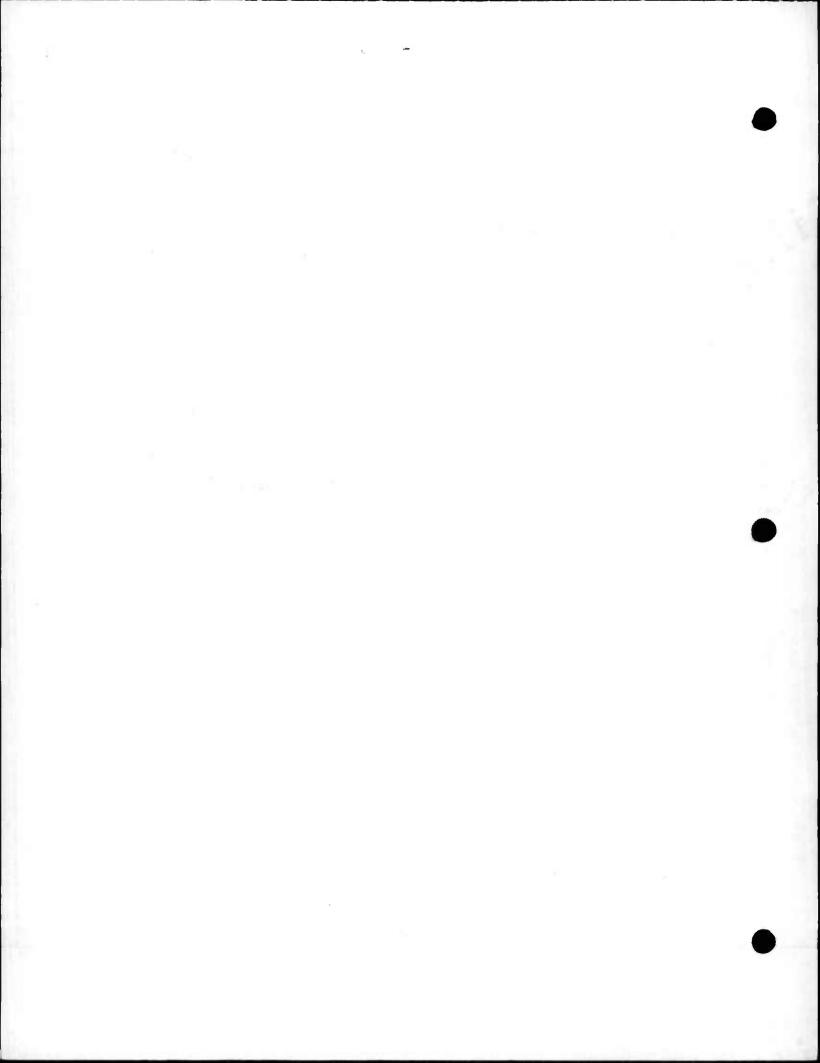
31. DATE FILED (Month, Day, Year)
APR 21 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

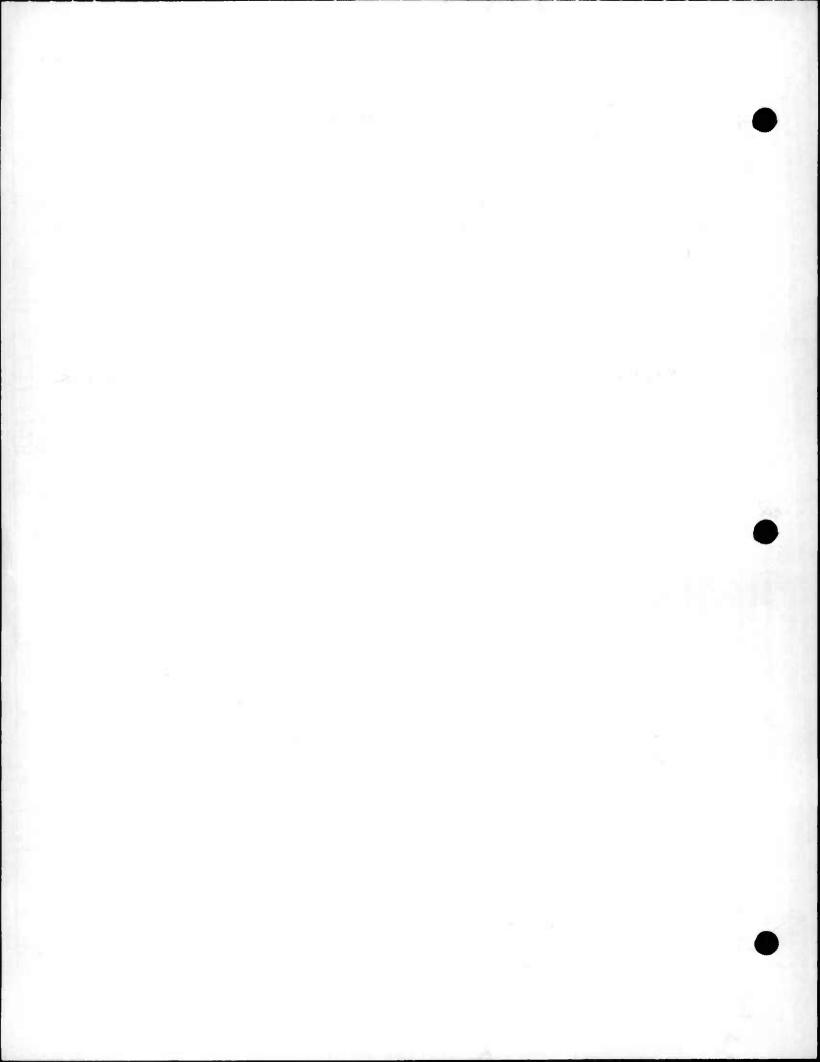
VIJAY K. NELLORE, M.D., VA Medical Center, Perry Point, MD

32. REGISTRAR'S SIGNATURI

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH April 17, 3. TIME OF DEATH Arthur Morton Meranski 17, 1995 4:20P 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12/1/1919 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS Permit. Pages 1. 2. 3 should 1 📈 M 2 🗌 F DAYS HOURS VBS 048-09-1931 75 Connecticut 9a. FACILITY NAME (if not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Perry Point VAMC Perry Point Cecil 10e. STATE 10c. CITY, TOWN OR LOCATION 10b COUNTY 10d. INSIDE CITY Maryland Harford Aberdeen 1 TYES 2XXNO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? r attending physician. use as the burial-transit 836 Randolph Drive 21001 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ₩ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. 21215-0020 1 Never Married 2 Merried If yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 TES 2 NO Specify: ¥ Specify 3 Widowed 4 Divorced WW II, Korean White ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only ō jo Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 4 Military detached U.S.Army once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname 8 notified at Harry Meranski Taylor Sarah BE page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Betty J. Meranski 836 Randolph Dr. Aberdeen, MD 21001 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Removal from State must be 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE funeral director, Donation 5 - Other (Specify) _ 4/25 Arlington National Cemt. Arlington, Virginia medical examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 D in by the f 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart fallure. List only one cause on each line. Interval Batwean 0 filled IMMEDIATE CAUSE (Final Onset and Death or other traumatic event, the disesse or condition_ and completely f burial, crematio . Cancer of Lung with Metastasis of Brain reauiting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events the attending p resulting in death) LAST shows any Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by t Health and 1X YES 2 NO DF DEATH? 1 TYES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item **EXAMINER?** HOSPITAL: OTHER: 1 N Inpatiant 2 - ER/Outpatient 3 - DOA OR ATTENDING PHYSICIAN: 1 TYES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) ō 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 🔀 Natural 1 YES 2 NO DIRECTOR: After the hours after death w BY 2 Accident Investigation 28e. PLACE OF INJURY - At home, farm, street, fectory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 🔲 Homicide Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If IN HOSPITAL 2 MEDICAL EXAMINER: On the beels of exemination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day Year) 뿔 8 Reclou D21779 ▶4-17-95



	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle,	4				F DEATH		AL HYGIEN REG. NO			
	_	_			MAH	AN	2. DAT	E OF DEATH	W 1	3. TIME OF DEATH	
	James 4. Social Security Number	Bruce s. sex	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DM	E OF BIRTH	10	BIRTHPLACE (State or Foreign	М
	484-26-2268	15/□ M 2 □ F	68	YRS.	MONTHS DAYS		(Mo	nth, Day, Year) -6-26	M	Country)	
	9e. FACILITY NAME (If not institution,	give street end number)	00		9b. CITY, TOW	OR LOCATION OF E		-0-20		Y OF DEATH	
DIRECTOR	302 St. Ives				Seve	erna Par	ck		Anne	ARunde1	
) bi	10a. STATE 10b. CO			10c. CITY	r, TOWN OR LOC	CATION				10d, INSIDE CITY	
=	Maryland A	nne Arund	e 1	Sev	erna I	Park				LIMITS?	
A A	10e. STREET AND NUMBER			1001		101. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?	
FUNERAL	302 St. Ives	Drive				21146	5		U	SA	
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E E	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or 5	(Gi	ve kind of w Do NOT us	rork done during i	most of working		D. KIND OF BU	SINESS/INDOS	H	
길릴	12	4	"	Pub	lic Af	fairs		U.S	. Cus	toms	
once.	17. FATHER'S NAME (First, Middle, Las					18. MOTHER'S N	AME (First		Surname)		
75		MAHAN			_	MAR	6-A	RET	R.	MOECK	
TO BE	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Stree	t end Number or Rura	Route Nu	mber, City or Tow	n, State, Zip Co	ode)	
9 -	James M. Maha	a n					re M	iller	svill	e MD 21108	
must	20e. METHOD OF DISPOSITION 11 Burlel 2 Cremetion 3		cemetery, crer	matory or ot	F DISPOSITION (1	-	-	y or Town, State	
E	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		- IMD V∈	eter	ans Ce	metery	4-2	1-95 (Crown	sville. MD	
examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home									1 Home	
	495 Ritchie Hwy Severna Park MD 211										1 4
medical	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximeta interval Between										
	IMMEDIATE CAUSE (Final		: 4	,		4				Onset and Dec	
event, the	disease or condition resulting in death)	8	Verbru	enter	andy	Umin				Minut)
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N N			101/20-		11		77			Hyler	
	Sequentially list conditions,	OUE TO	(OR AS A CONSEC	UENCE OF	inder.	ny ofa	ry				
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IFICATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	C	renj	when	disens	The state of the s			4 yers	
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IPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFIC	If any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent cond DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigat 3 Suicide 8 Could no determine 29e. CERTIFIER (Check only one) 2 MEDICAL EXA 29b. SIGNATURE AND WILE OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CERTIFIED AND WILL OF CER	DUE TO d. DITRIBUTE TO CA AL HOSPITAL: 1 Inpatient 2 28e. OATE OF (Month, E be de WHYSICIAN: To the best of MINER: On the best of e TIFIER WHO COMPLETED CAU CHUNC 32. REGISTRA	(OR AS A CONSECTION OF INJURY — All hor stc. (Specify) The samination end/or in the samination	DUENCE OF DEAT DOA 29b. TIME THE OCCUPY TH	The underlying the un	UNCERTAL Deprivation of the end place, end dudeath occurred at the second of the end place.	8 Ott 28d. Ot 28f. LO Cit	PERFOR 1 YES 2 Her (Specify) ESCRIBE HOW II CATION (Street of yor Town, Stete) Buse(e) end men te and piece, en	MED? NO NJURY OCCUP and Number or ner ee stated, d due to the c	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number,	



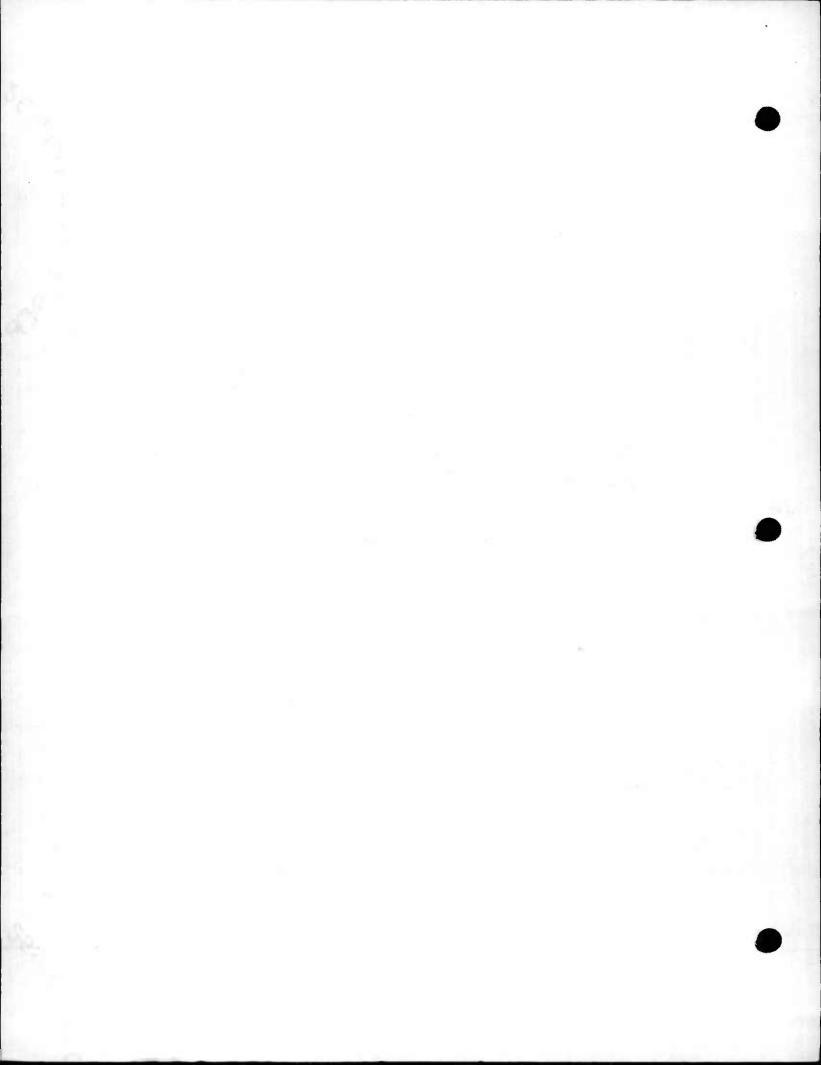
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Tours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1. DECEDENT'S HAME (First, I	Widdle, Last)				OAIL O			2. DATE OF DEATH		3	, TIME OF DEATH	
	Laura 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest					Cynthia McCall MONTH					95	1,20 ld "	
1 8	216-76-4537 1 D M 2 OF 9 7			YRS.				7. DATE OF BIRTH 1	967	Country)	ACE (State or Foreign		
	80. FACILITY NAME (If not inst	iltution, give st	treet and number)	~ (9b. CITY, TOW	OR LOCAT	IOH OF DEA	4/27/4	Sec cou	Mary I		
DIRECTOR	710 Hances Po	oint F	Road			North					ecil		
	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY				10c, CIT	Y. TOWN OR LO	ATIOH					Od. IHSIDE CITY	
E E	Maryland	Cec	11			No	rth E	ant			- 1	LIMITS?	
A.	10e. STREET AND NUMBER						10f. ZIP CO			10g. CIT	CITIZEN OF WHAT COUNTRY?		
FUNERAL	710 Hances Po	oint R	Road		21901					Un:	United States		
	11. MABITAL STATUS 1 Never Married 2 N	ferried		YES 2 TH	10 If yes, specify Cuban, Maxicen, Puarto Rican, etc.)					or Ho—	14. RACE Black, 1	- American Indian, White, etc.	
) BY	3 Widowed 4 Divorce							Specify:			Specify:	White	
Ī	(Specify only		CATIOH completed)	(G)	CEDENT'S ve kind of a Do NOT us	VSUAL OCCUPA	TION most of work	ing	16b. KIHD OF BUS	SIHESS/IH	DUSTRY		
COMPLETED	Elementary/Secondary (0-1	12}	College (1-4 or 5	+)		Secreta	3 3457		A * * * * * * * * * * * * * * * * * * *		055:		
O.	17. FATHER'S NAME (First, Mid	Idla, Last)		П	gai	DECLET		THER'S NAM	Attorne		UIIIC	e	
BE C	Wilmer C. Mc	Ca11,	Jr.				G	ladvs	Miller				
5 B	19a. IHFORMANT'S HAME (Typ			198	. MAILIHG	ADDRESS (Street			oute Number, City or Town	n, State, Zi	(p Code)		
-	Wilmer C. Mc		Jr.		706 E	lances]	Point	Road	, North Ea			1901	
	20e. METHOD OF DISPOSITIO 1 ☑ Burlel 2 ☐ Cremetion	3 Reme	oval from State	20b. PLACE A cemetery, cree	NO DATE	of DISPOSITION ther place)	Neme of		DATE 20c. LO	CATIOH —	City or Town	n, State	
	4 Donation P Other (S		ENSER	North	East	Metho	dist	Cem.	4/17 Nor	th Ea	ast, N	Maryland	
	11/2/9	11	1/10	. 5	5				1 Home				
_	23. PART I. Enter the dis	0-	Vua		^-				Street, N			MD 21901	
	shock, or her iMMEDIATE CAUSE (Fina	srt fsiiure, l Il	List only one cau	ise on each line						-	reat,	Approximata interval Between Onset and Death	
	disease or condition resulting in death)	>	Melas	COR AS A CONSEC	OLEHCE O	and Co	me	- 8	Cervix	_			
Z	Sequentially list condition		b					V					
ATIC	if any, leading to immedicause. Enter UNDERLYIN	iate	DUE TO	(OR AS A COHSEC	OUENCE O	F):							
E S	CAUSE (Disease or injury that initiated events		DUE TO	(OR AS A CONSEC	UEHCE O	F):							
CERTIFICATION	resulting in desth) LAST		d										
	PART ii. Other significan	t condition	s contributing to	death but not n	esuiting	in the underly	ing csuse	given in F	Part I. 24a. WAS AH PERFOR		A	YERE AUTOPSY FINDINGS WAILABLE PRIOR TO	
AEDICAL									1 YES 2	□ но		OMPLETION OF CAUSE OF DEATH?	
-	DID TOBACCO	USE	ONTRIBUTE	TO CAUS	E OF	DEATH	YES I	1 NO	_		1	YES 2 HO	
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?					26.		DEATH (Che	ck only one)	- "			
YSI	1 TYES 2 HO			ER/Outpatient 3			ome 5 🗆 F	Realdence (3 Cher (Specify)				
	27. MAHHER OF DEATH 1 Hetural 5 P		28e. DATE OF (Month, D		28b. TIM IHJ	URY	HJURY AT WORK? YES 2	_ HO	28d. DEŞCRIBE HOW II	HJURY OC	CURED		
ЭВУ	2 D Sulaida	ould not be	28e. PLACE C	F INJURY — At ho	me, farm, :		1,1	- NO	28f. LOCATION (Street a	nd Numbe	r or Rurel Rou	ite Number,	
Ë		etermined	building,	elc. (Specify)					City or Town, State)				
COMPLETED									to the cause(e) end man				
Š	2 MEDIC	AL EXAMINE	R: On the basie of a	xemination end/or I	nvestigatio	n, in my opinion	death occu	ured at the t	lime, date end place, an	d due lo t	he couse(e) a	and menner ee stated.	
BE (296. SIGHATURE AND TITLE O	OF CERTIFIER	112				29c. LIC	EHSE NUM	BER	29d. DAT	TE SIGHED (A	Aonth, Day, Year)	
5	30. HAME AHD ADDRESS OF	PERSON WIL	O COMPLETED CALL	E DE DEATH ATE	1 270 (%	Orient	1)	5500	١٩	P	111319	5	
	D6 0 W	11LA	CV	RE	1	38 C	ath	edra	i din	rel	FI	ICTON	
	31. DATE FILED (Month, Day, No.	1995	22. REGISTRA	HIS SIGHATURE	16						,	MD	
پ	M11/4+				-						214	2 DHMH-16 Rev 1/89	

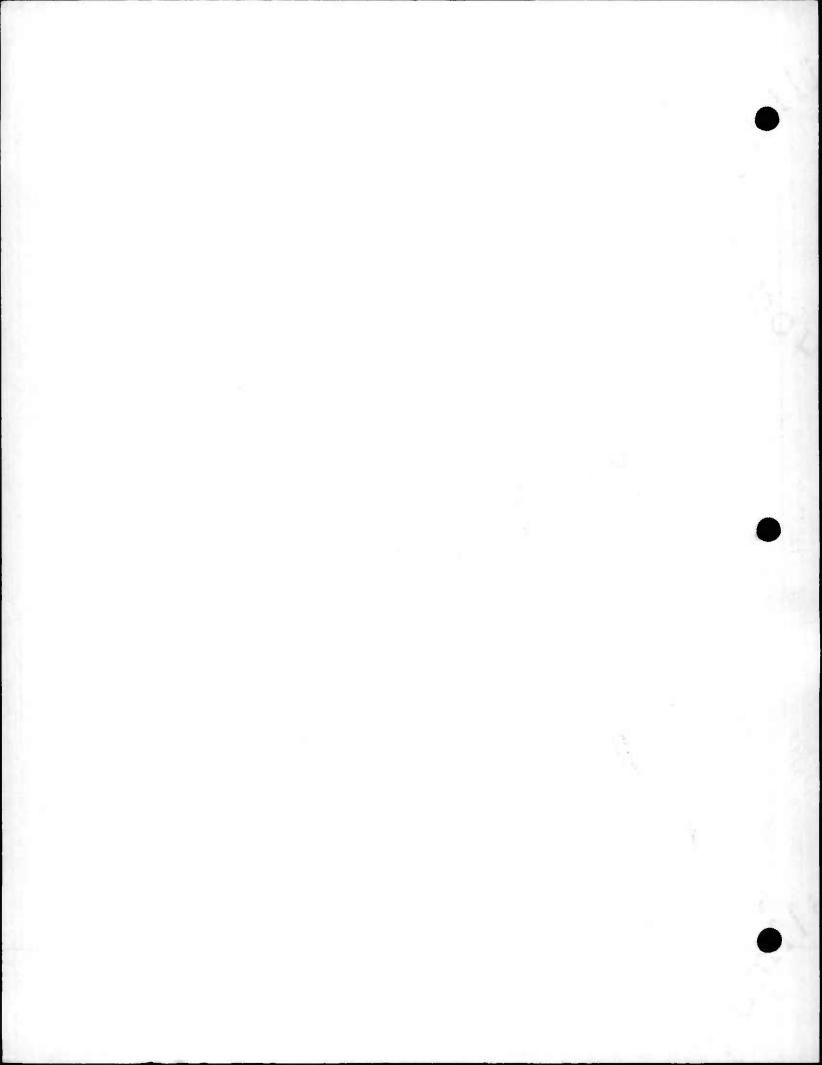


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and received within and received within and received within and received within and received within and received within a steen death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

6

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATH
	Mildred B. Malco	olm_				4-11-95	AY YEAF	10:04 A. M
		The second	'In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7, DATE OF BIRTH (Month, Day, Year)	S. BIF	RTHPLACE (State or Foreign untry)
	221-22-6750	□ M 🛠 🗆 F	88 YRS.	MONTHS DAYS	HOURS MIN.	8-2-06		ryland
	9e. FACILITY NAME (If not institution, give stree			96. CITY, TOWN O	R LOCATION OF O	EATH	9c. COUNTY OF	
9	315 George Stree	et		Chesar	eake C	lity	Cec	i1
	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR	Maryland Ced	ci1		esapeak				LIMITS?
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	315 George Stree	et			21915		22.5	
3	11. MARITAL STATUS	2. WAS DECEDENT EVER II	U.S. ARMEO	13. WAS OEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	or No- 14. R	S . A . ACE — American Indian,
BY F	1 Never Merried 2 Merried	FORCES? 1 YES	ATES NO		2 NO Specific	nn, Puerto Rican, etc.) fy:		lack, White, etc.
	3 Widowed 4 Olvorced				Λ			White
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade cor	TON mpleted)	(Give kind of I	VOIAL OCCUPATION OF MORE	IN st of working	16b. KIND OF BU	SINESS/INDUSTRY	Y
1 2	1	College (1-4 or 5+)	Retai	l Sales	}	Depart	tment :	Store
N N	17. FATHER'S NAME (First, Middle, Last)							
		7				AME (First, Middle, Maiden		
B	Alec B. Richa Res. INFORMANT'S NAME (Type/Print)	rdson	19h MAII ING	ADADERS (Street o	Clara	E. Cott: Route Number, City or Tow	ingham	
은	Judith A. Stake	r						/1915
3	20a. METHOD OF DISPOSITION	20b	PLACEANDDATE			Chesapeal	CE CITY OF CATION — CITY OF	Town State
	1 Donetion 5 Other (Specify)		etery, crematory or o	ther place)				ster, Pa.
	21. SIGNATURE OF FUNDIAL SERVICE LICEN		A. F.	22. NAME AN	D ADDRESS OF FA	CILITY OF		
	Aby	20		Gee F	uneral	Home Ell	te. Ma	ain St., Md. 21921
_	23. PART I. Enter the diseases, or con	anii etiana that asusaa	date death. Do		40 M 4000 ES	Elr	CCOH, N	
	snock, of heart fellure. Lis	t only one ceuse on e	ech iine.	ot anter the mo	da ot dying, suc	as cardiec or resp	iratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	MOBALC	20120	hos	vb/	ancer		Onset and Death
	resulting in desth) a	DUE TO (OR AS A	CONSEQUENCE OF	- LI CU	SUC	MICEN		
-			OUNDED DE NOT OF	<i>y</i> -				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	j:				
3	cause. Enter UNDERLYING CAUSE (Disease or injury							
E	thet initiated events	OUE TO (OR AS A	CONSEQUENCE O	7):				
H	resulting in death) LAST							
	PART ii. Other significent conditions of	contributing to deeth b	ut not resulting	n the underlying	cause given in	Part I. 24a. WAS AN	LAUTOPSY	24b. WERE AUTOPSY FINDINGS
CAL						PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI						1 TYES 2	S NO	OF DEATH?
	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES I NO	N	ĺ	1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	7831 10			ACE OF OEATH (CA			
Sic		IOSPITAL: ☐ Inpetient 2 ☐ ER/Outp	etlent 3 DOA	OTHER:		6 Other (Specify)		
Η	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM	E OF 28c. INJ	URY AT	28d. OESCRIBE HOW	NJURY OCCURED)
ВУ Р	1 Nstural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		RK7 'ES 2 NO			
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	street, factory, office)	261. LOCATION (Street		al Route Number,
	4 Homicide determined	burning, acc. (Spec	муј			City or Town, State)		
2	299. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my know	ledge, death occurn	ed at the time, date	end piece, end due	to the ceuse/e) end me	nner ee stated.	-
COMPLETED	one) 2 MEDICAL EXAMINER:							se(s) end menner ee stated.
-	200. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IED (Month, Day, Year)
BE	/ Minner	15			0451	55	12A	00015.
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF OE	ATH (ITEM 27) (Type	Print)	- 10 1	~	. //	
	John Mulvey,				. Elk+	on, Md.	21021	
		32. REGISTRAR'S SIGN	NURE	202001	LILING	OII, PIU.	61771	
	WAKT & 1992 &	the divideor	ardall					
	M.							



Maryland 9c. COUNTY OF DEATH WICOMICO

10g. CITIZEN OF WHAT COUNTRY? USA

3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY LIMITS? 1 X YES 2 | NO

14. RACE — American Indian, Black, White, etc.

White

7:45 P. M

REG. NO.

			, Middle, Last)			m.	111:	Le	^	MONT	TH E	49	YEAR 3. TIME	
			BER	5. SEX	6. AGE			_		11/1		-	8. BIRTHPLACE (S	
		215_36_0308		1 N 2 F			MONTHS	DAYS	HOURS MIN.				Country)	
pino			stitution, give	1 22		33	9h CITY	TOWN C	OR LOCATION OF D		1932		Maryland	
60	S S				AL C	ENTER				EAIH			ICOMICO	
	IRECT	RESIDENCE OF DEC	CEDENT											
Sages		SACHESIN	10b. COUNT	TY.		10c. CIT	Y, TOWN O	R LOCAT	TION				10d. INS	
nit.				sex		La	urel						1 📉 YE	
Led 1	₹							101	. ZIP CODE			10g. CITIZI	EN OF WHAT COL	
an. ransh	W		k Circ	·				_ 1	9956				USA	
or attending r use as the	5		Married	FORCES? 1	XYES	2 NO	13. W	AS OEC	ENDENT OF HISPA	NIC ORIGII	N? (Specify Ye	s or No-	4. RACE — Amer Black, White,	
	≽					ATES					Specify:			
		15. DEC	EDENT'S EDI		<u>e</u>	16. DECEDENT'S	I I OO	CHIDATIC		1.00			Whi	
		(Specify onl	y highest grad	e completed)		(Give kind of a	work done di se retired.)	uring mo	st of working	166	I. KIND OF BU	SINESS/INDU	STRY	
	PL	12	F-12)	College (1-4 or 5	*)									
e hos	OM	17. FATHER'S NAME (First, M	liddle, Last)			11104140		1001		ME /Elmt	Miridia Maida	Cumamal		
at be d		Alfred Edwa	ard Mo	Allister						, ,		,		
ined iould fied	00	19a, INFORMANT'S NAME (7											Sa da l	
5 5	입	Brian P. Me	cAllis	ster										
A 8 0					206									
6 m		1 2 Suriet 2 Cremation 4 Donation 5 Other	n 3 Ren	noval from State	Cent Di	etery, crematory or o	ther place)	tori	an Cam					
	İ			CENSEE	111	a alast.		_			2 144	IIUNE C	LLY, PELY.	
eath. funera	!	×)	110	mi.1							ome			
ter d the i oval.		Olde	12	muc	20-		PC	Bc	x 64, Po	ocomo	oke Ci	ty, Mc	2185	
in by rem		23. PART I. Enter the di shock, or h	iseases, Dr eert fallure.	Complications the	t caused	the death. Do n	not anter t	he mo	da of dying, auc	h aa card	diac or resp	Iratory arres		
Filled on Filled	- 1	IMMEDIATE CAUSE (Final											Int On	
thin 2 rtely 1 matio		resulting in deeth)	→	a. D: +v	use	Lurge	Ce 1,	1 1	you sho.	ma			6	
od wit	- 8			DUE TO	(OR AS A	CONSEQUENCE OF	F):		7-0					
atic	8	Sequentially list conditi	inna C	b										
be es	Ě	if any, leading to immediate												
	길	CAUSE (Disease or Injury C.												
			т Т	506 10	(OH AS A	CONSEQUENCE OF	-):							
= 0 =	労用			d										
Me Me		PART II. Other significa	nt condition	na contributing to	deeth b	ut not resulting i	n the und	leriying	ceuse given in	Part I.			24b. WERE AU	
that ed by th an	5												COMPLET	
sign Healt W&	빌									_ 4	123	. I NO	OF DEATH	
. 6		DID TOBACCO U	SE CONT	RIBUTE TO CA	USF O	F DEATH YE	SIN	N O	LINICEPTAIL				1 TYES	
has Dep	₹ I	25. WAS CASE REFERRED TO							- OTTCERTAIN					
V: The cate h State [0 1	EXAMINER?		HOSPITAL:	FB/Outo	etlant 3 🗆 DOA	OTHER:							
2 5 C	S	1 YES 2 NO		1 Klenetlant 2					5 Residence					
SICIAN certific the S	HYS	1 YES 2 NO		1 Superlant 2 28a. DATE OF	INJURY							N HIRY OCCII	BED	
PHYSICIAN: The law rethis certificate has be haith the State Dept.	Y PHYSICIAN	27. MANNER OF DEATH	Pending		INJURY	28b. TIMI		8c. INJU	JRY AT RK?			NJURY OCCU	RED	
三 元 三 三	B	27. MANNER OF DEATH 1 Netural 5 2 Accident	rivestigation	28a. DATE OF (Month, D	INJURY ay, Year)	28b. TIMI	E OF 2	1 Y	JRY AT RK? ES 2 NO	26d. DES	CRIBE HOW			
三 元 三 三	ED BY	27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6		28e. DATE OF (Month, D	INJURY ay, Year)	28b. TiMi	E OF 2	1 Y	JRY AT RK? ES 2 NO	26d. DES	CRIBE HOW	and Number or	RED Rural Route Numb	
OR ATTENDING PHY JIRECTOR: After this ours after death wit lem 28 is marke	ETED BY	27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide	restigation Could not be detarmined	28e. DATE OF (Month, D	INJURY ay, Year) F INJURY etc. (Spec	28b. TiMi INJI — At home, ferm, s	E OF 2 URY M street, factor	1 Y Y	JRY AT RK7 ES 2 NO	26d, DES	ATION (Street or Town, State)	and Number or	Rural Route Numi	
OR ATTENDING PHY JIRECTOR: After this ours after death wit lem 28 is marke	ETED BY	27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Sulcide 6 4 Homicide 29e. CERTIFIER (Check only)	restigation Could not be detarmined	28e. DATE OF (Month, D 28e. PLACE O building,	INJURY ay, Year) F INJURY etc. (Spec my knowle	— At home, ferm, s	E OF URY M	1 Y	JRY AT RK? ES 2 NO	26d. DES	ATION (Street or Your, State)	and Number or	Rural Route Numi	
OR ATTENDING PHY JIRECTOR: After this ours after death wit lem 28 is marke	ETED BY	27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Sulcide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDH	rivestigation Could not be determined IFYING PHYS CAL EXAMINE	28e. DATE OF (Month, D 28e. PLACE O building.	INJURY ay, Year) F INJURY etc. (Spec my knowle	— At home, ferm, s	E OF URY M	1 Y	JRY AT RK? ES 2 NO	26d. DES	ATION (Street or Your, State)	and Number or	Rural Route Numi	
DIRECTOR: After this hours after death with them 28 is marke	ED BY	27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Sulcide 6 4 Homicide 29e. CERTIFIER (Check only)	rivestigation Could not be determined IFYING PHYS CAL EXAMINE	28e. DATE OF (Month, D 28e. PLACE O building.	INJURY ay, Year) F INJURY etc. (Spec my knowle	— At home, ferm, s	E OF URY M	1 Y	JRY AT RK? ES 2 NO	26d. DES 28f. LOC. City to the cautime, data	ATION (Street or Your, State)	and Number or	Rural Route Numi	
	requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. John signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, or Health and Mental Hypiene prior to burial, cremation, or removal. Shows any injury, or other traumatic event, the medical examiner must be notified at once.	requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. Seen signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOF	William 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 215—36—0398 9e. FACILITY NAME (If not in PENINSULA) RESIDENCE OF Decision PENINSULA RESIDENCE OF Decision 10e. STREET AND NUMBER 3 Millcree 11. MARITAL STATUS 1	William 4. SOCIAL SECURITY NUMBER 215-36-0398 9e. FACILITY NAME (II not institution, give PENINSULA REGION PENINSULA REGION RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY 10e. STATE 10e. COUNTY 10e. STATE 10e. COUNTY 10e. STATE 10e. COUNTY 10e. STATE 10e. STATE 10e. COUNTY 10e. STATE 10e. STATE 10e. COUNTY 10e. STATE 10e. STATE 10e. STATE 10e. STATE 10e. STATE 10e. STATE 10e. STATE 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. SEQUENTIAL STATUS 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. STATE 11e. MILLIAN PROPERTY 10e. MILLIAN PROPERT	4. SOCIAL SECURITY NUMBER 215-36-0398 1 X M 2 F 215-36-0398 9a. FACILITY NUMBER PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X M 2 F PENINSULA REGIONAL MEDIC. RESIDENCE OF DECEDENT 10b. COUNTY Delaware Sussex 1 X MAPITAL STATUS 1 Never Merried 1	William M. 4. SOCIAL SECURITY NUMBER 215-36-0398 9. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CITY NUMBER 9. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CITY NUMBER 10. STATE 10. COUNTY Delaware 10. STATE 10. COUNTY Delaware 11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 WESS 13. Wildowed 4 M Divorced 14. Mover Merried 2 Merried 3 Wildowed 4 M Divorced 15. DECEDENT'S EDUCATION (Specify only inhighted prade complained) 16. COUNTY Delaware 17. FATHER'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) Alfred Edward McAllister 19. INFORMANT'S NAME (First, Middle, Last) 20. METHOD OF DISPOSITION 1 Last Surfer 2 Competition 3 Removal from State 21. SIGNATING FUNERAL SERVICE LICENSEE 22. PART I. Enter the diseases, Dr complications that caused shock, or heart failure. List only one cause on estimated the cause. Enter UNDERLYING CAUSE (Pissal disease or Injury that initiated evants resulting in deeth) LAST DUE TO (OR AS A	William M. ACA DECEMBENT AND A CONSEQUENCE OF DECEMBENT OF DISPOSITION 1 DATE OF DISPOSI	William M. A. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 215-36-0398 9a. FACILITY NAME (if not institution, give street and number) 9a. FACILITY NAME (if not institution, give street and number) 9b. FACILITY NAME (if not institution, give street and number) 9c. CITY, TOWN OF DECEDENT 10a. STATE 10b. COUNTY 10c. STATE 10b. COUNTY 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. CITY, TOWN OF DECEDENT 10c. STATE 10c. CITY, TOWN OF DECEDENT 10c. CITY, TOWN O	William M. 4. SOCIAL SECURITY NUMBER 5. SEX 215-36-0398 1	William M. MCAII.SEC. 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 215-36-0398 1	William M. A. SOCIAL SECURITY NUMBER 1.5 SEX 1	William M. M. A. SOLAL SECURITY NUMBER 1. S.E. A. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (in yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (In yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (In yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (In yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (In yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (In yet. bat binding) FUNCES 1 YEAR S. DUTE OF BRITTH 9/2/2/1932 1. S. AGE (IN YET AND NUMBER 1 YET) FUNCES 1 YET AND NUMBER 1 YE	William M. 4. SOCIAL SECURITY NUMBER 5. SEX 1. A MG (in yr. set binding) 215—36—0398 1. We 2 F 55 yrs. 55 yrs. 1. South 1. West control 1. We	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

James

31. DATE FILED (Month, Day, Year)
APR 12

E.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

N.O.

32. REGISTRAR'S SIGNATURE

145

Tulis Denisem Rondollo

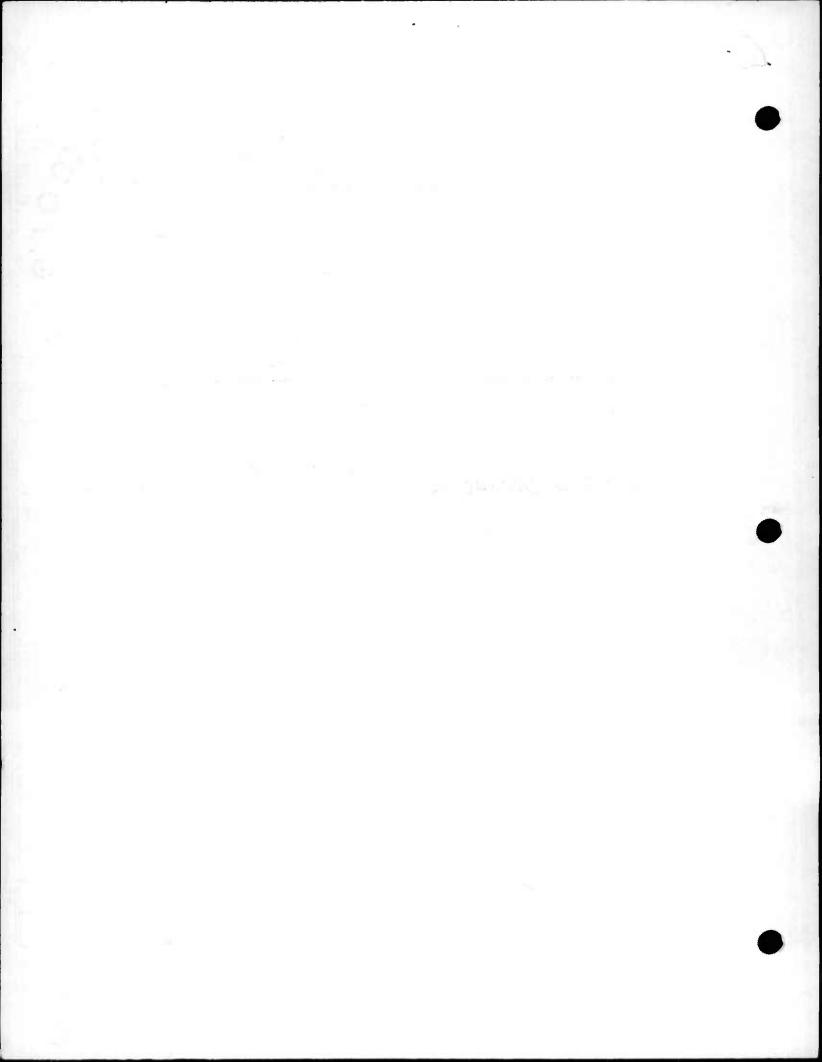
Mortin

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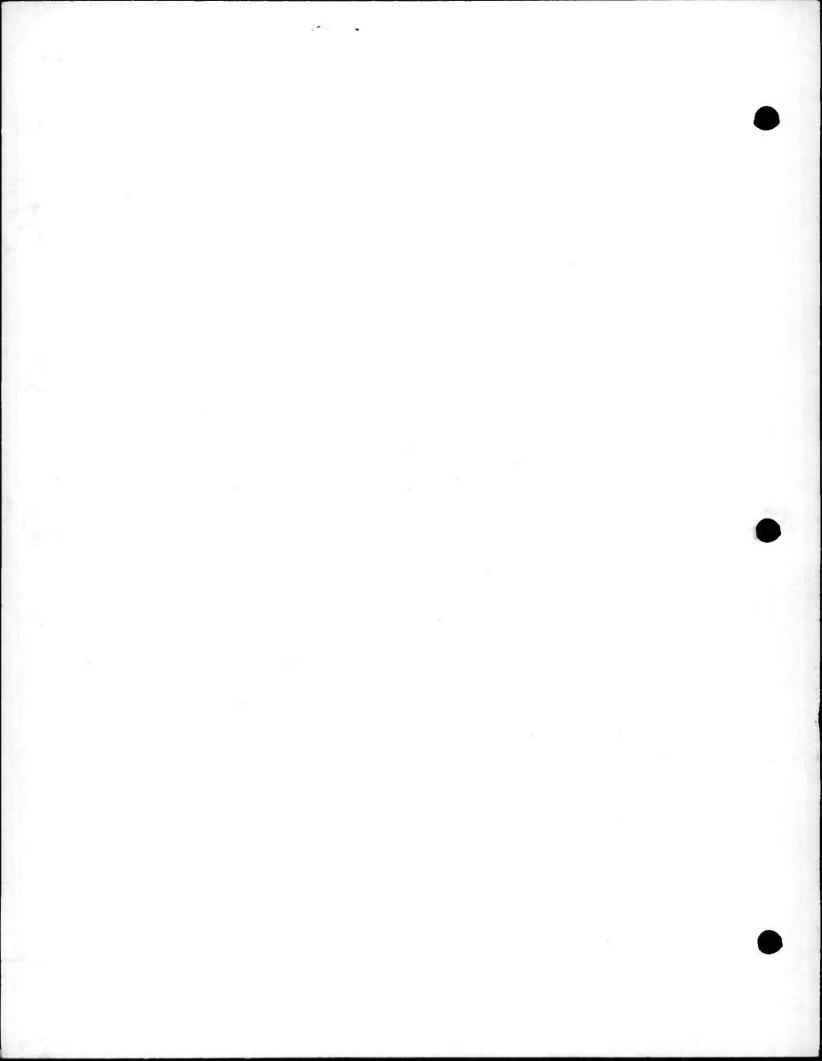
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8

comoke City, Maryland lity, Md. 21851 espiratory arrest, Approximate Interval Between Onaet and Death 6 montas AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? S 2 | NO 1 TES 2 NO W INJURY OCCURED set and Number or Rural Route Number, late) nation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 95 E. Carroll St., Salisbur DHMH-16 Ray 1/89



,		FOR 1 - STATE REGISTRAR	STATE OF MAR			RTMENT OF I		MENTAL HYGIEI		10010		
\bullet , x^{\prime}		1. DECEDENT'S NAME (First, Middle, Last) Walter Ediso	mill			IOATE OF	DEATH	2. DATE OF DEATH		3. TIME OF DEATH		
2, 2, 3 should (5, 1, 2, 3)		4. SOCIAL SECURITY NUMBER 063-24-2147	5. SEX 6. AC	GE (in yrs. les	st birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 28.	6.	BIRTHPLACE (State or Foreign Country)		
2, 3 shou	TOR	98. FACILITY NAME (If not institution, give a Fallston General RESIDENCE OF DECEDENT					or location of D ston		9c. COUNTY	of DEATH		
permit. Pages 1,	DIRECTOR	10s. STATE 10b. COUNTY	rford			y, town or Loca Bel Air	TION			10d. INSIDE CITY LIMITS? 1 □ YES 2√ NO		
ist.	IERAL	100. STREET AND NUMBER 25 Bonnie Ave.					1. ZIP CODE 210]	14	10g. CITIZE	N OF WHAT COUNTRY?		
215-0020 attending physician. se as the burial-transit	PLETED BY FUNI	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YO IF YES, GIVE WAR OF WWII	ES 2 T		Black, White, etc. Specify: White						
21 al or for u		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)	completed) College (1-4 or 5+)	(G life.	live kind of a Do NOT us		ost of working	166. KIND OF BUSINESS/INDUSTRY				
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	5+	PLO	ress	or of Ch		AME (First, Middle, Malde	cation	1		
YLL by the dibe distance	ш	Louis (nmn) M	iller				Hatti		Rose			
IE, MARYLAND by be retained by the hospit page 5 should be detached be notified at once.	TO BE	19s. INFORMANT'S NAME (Response)								ode)		
AOR e 6 m rector,	U)	20s. METHOD OF DISPOSITION 120 Burlet 2 Offenstion 3 10 Remote 1 Donation 1 Other (Specify)	oval from State	cemetery, cre	matory or o	Plawn Ce	metery 4	-13-95 CI		y or Town, State New Jersev		
SALT r death. e funeral. al.		21. SIGNATURE OF PURSERIAL SERVICE LC	- 18 Ma	Mille	_	Howard 1317	nd address of fo d K. McC Cokesbur	Comas III I V Rd., Abi	uneral	Home, P.A.		
ithin 24 hours after letely filled in by th emation, or remove nt, the medical		23. PART I. Enter the disease, or a shock, or heart failure immediate CAUSE (Final disease or condition resulting in death)	List Drily ona cause of	n aach lina	1,					interval Batween Onset and Death		
K 6875 executed w n and comp to burial, cr matic eve	CATION	disease or condition resulting in death) Sepsis Secondury to Urinary Tract In fection lake. Due to (or as a consequence of): 1 yperosmular State Due to (or as a consequence of): Due to (or as a consequence of):										
certificate be sing physician ygiene prior other trau	IFICAT	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents Due to (or as a consequence of):										
S, P. death le attend Aental H uny, or	L CERTIFI	PART II. Other algorificant condition	a contributing to death				a course almos la	Part i ar una si	1 AUTODOV	1 10/4		
COR signed by Health and	MEDICA	Azotemia., Parkisson	Hypernat	ceni.	~ /	Prior	STROK	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
> 0 -		DID TOBACCO USE CONTE						-X/		1 TYES 2 NO		
F VITAL SICIAN: The law certificate has the State Dep , or Item 23	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER: 4 □ Nursing Hom	e 5 🗆 Residence	8 ☐ Other (Specify)				
DIVISION OF VITA DR ATTENDING PHYSICIAN: The OIRECTOR: After this certificate hi nours after death with the State D tem 28 Is marked, or Item	ВУ РНУ	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJUR (Month, Day, Yes	r)		M 1 1	YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCUR	ED		
DIVISION OR ATTENDI DIRECTOR: A hours after di item 28 Is	TED	3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, stc. (S	IRY — At hor	me, farm, s	street, fectory, offic		261. LOCATION (Street City or Town, State		Rural Route Number,		
4 4 2 m	COMPLI		R: On the basis of sxamina							suse(s) and manner as stated.		
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT:	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	7.15				29c. LICENSE NUI	MBER - 0 /2-	29d. DATE SI	GNED (Month, Day, Year)		
			LYNCH m	0 .	4 27) (Type,	2 Not	th Au	012 e. Bei	Air,	nd.		
		31. DATE FILED (Month, Day, Year) APR 1 2 1995	Julia Muchan	Rardal	Ų,							
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S cert	th the	o De
IR: After this certif	nours after death with the State Dept. of Health and	tem 28 is marked, or item 23 shows any injury, or other traumativ
R: Aft	ter dea	1 18
ECTO	nours after	n 28
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	JANE OF WARTE	CERTIF	CATE OF	DEATH	REG. N	D.	
100	1. DECEDENT'S NAME (First, Middle, Lest)	lilm II	en			2. DATE OF DEATH	3 95	3. TIME OF DEATH
		The same of the later of the	In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	210-72-1077		96 YAS.			11/24/1	898	Kentucky
OB	90. FACILITY NAME (If not institution, give street IVY Hall Geria		ter	Bb. CITY, TOWN C	R LOCATION OF DE	ofe.	90-COUNTY	attimise
בֿל	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		10c CITY	, TOWN OR LOCAT	ION			10d, INSIDE CITY
DIRECTOR		Harford			rettsvi	1116		LIMITS?
7	10e. STREET AND NUMBER	202 20 02 02			ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
ER/	1628 Du la	aney Driv	е		2108	34	1	U.S.A.
BY FUNERAL	11. MARITAL STATUS 12 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		IIC ORIGIN? (Specify) n, Puerto Ricen, etc.)	ee or No. 14.	RACE — American Indian, Black, White, etc. Specify:
	15. DECEDENT'S EDUCATION	ION	16. DECEDENT'S	USUAL OCCUPATION	NAI .	16P KIND OE 8	USINESS/INDUS	White
COMPLETED	(Specify only highest grade com	npleted)		vork done during mo		IOD. KIND OF B	OSINESS/INDOS	183
PLI	11	College (1-4 or 5+)	Но	usewif	e	F	ome	
OM	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide		
BE C	Henry C.	Caudil.	1		Rebe	ecca	Peni	nington
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street 8	nd Number or Rural F	Route Number, City or To	own, State, Zip Co	de)
_	Madlyn Meister			same as				
- 8	200 METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removal	from State	other place)				OCATION — City	
- 31	4 Donetion 5 Other (Specify)	SEE ()	Ignview		Gardens		allst	on, Maryland
	→ M. Gladder	~ Kurk-	TI.	K	urtz Fu	neral H		and
	23. PART i. Enter the diseases, or com shock, or heart fallure. List			ot anter the mo	de of dylng, eucl	h sa cardisc or rec	piratory erreel	t, Approximete
	iMMEDIATE CAUSE (Final disease or condition resulting in deeth) e	Sex	ous					Onset and Daath 5 doys
			CONSEQUENCE OF	F):	Hahim	· Pre	001	ne week
ON	Sequentially liet conditions, b		A CONSEQUENCE OF		1709,00	1 1 4	W	
CERTIFICATION	if any, laeding to immedieta cause. Enter UNDERLYING			,				ļ
Ħ	that initiated events	DUE TO (OR AS /	A CONSEQUENCE OF	F):				
ERI	resulting in deeth) LAST							
	PART II. Other algnificent conditions of	contributing to death t	out not reaulting	in the underlyin	g ceuse given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
DICAL	1 Severe Ma	I muhitia			Direction and the	PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED	@ Corenory a	stery de	rease /	Atrial.	Librilla	Fian	A	OF DEATH?
ž.	1 Anemia.	M De	my delat	ion.	,			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:			ACE OF DEATH (Ch	eck only one)		
YSi	1 🗆 YES 2 🖾 NO 1	☐ Inpatient 2 ☐ ER/Outp				6 Other (Specify)		
H	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	26b, TIM	URY WO	URY AT DAK?	28d. DESCRIBE HOV	V INJURY OCCUP	1ED
В	2 Accident Investigation	28e. PLACE OF INJURY	Y — Al home ferm		YES 2 NO	26f, LOCATION (Stre	at and Number or	Pural Boula Number
ETED	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Spe	icify)	attent, factory, orne		City or Town, Ste		rure route varion,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	_						couse(s) and menner as stated.
00		The State of Exempliation	Jimor arresigant	, in my opinion, i				
BE	296. SIGNATURE AND TITLE OF CENTIFIER Matthe Decide	ean. WD			D-38		≥ 4-	GIGNEO (Month, Day, Year) - 6- 95
5	30. NAME AND ADDRESS OF PERSON WHO CO			ROADU	DAY, B	ALTIMOR	e, MD)-21231.
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE					

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1, OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OFATN 3. TIME OF DEATH DAY 1995 MARRY MILLER MAURICE 1.WA 14 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign 1 M 2 - F 204-03-2248 72 SEPT. 14. PENNSYLVANIA Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND CARROLL TANEYTOWN permit. 1 🗌 YES 2 🔯 NO FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? detached for use as the burial-transit 3112 ROOP ROAD 21787 USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 TYES 2 TYNO BY Specify Specify 3 Wildowed 4 Divorced CAUCASIAN COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. OECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INOUSTRY during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 10th TRUCK DRIVER TRUCKING 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be 듉 HARVEY **ABRHAM** MILLER BE notified ; MARGARET FRANCES RILEY 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DEBORAH D. BAUGHER TANEYTOWN. roop road MARYLAND 21787 9 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 20a. METHOO OF DISPOSITION

1 Striet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) emetery, crematory or other place)
RESTHAVEN CEMETERY 4/18 HANOVER, PENNSYLVANIA examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET hours after death. even the SKILES FUNERAL HOME TANEYTOWN. MD 21787 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one ceuse on each line. medical filled in by Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ in M yanhene les and completely fi to bunal, cremation 4/4/95 event, reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) 4/10/95 traumatic CERTIFICATION Sequentially list conditiona, 2 DUE TO (OR AS A CONSEQUENCE OF)physician if any, leading to immediate cause. Enter UNDERLYING death certificate be phor CAUSE (Disease or Injury other that initiated events attending reauiting in deeth) LAST 10 the atten Mental H injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN? any 1 YES 2 DONO shows 1 _ YES 2 _ NO been t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. t PHYSICIAN: MP 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) The certificate h fem **EXAMINER?** HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Name 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATN 28c. INJURY AT WORK? 28e. DATE OF INJURY 28b. TIME OF this c 28d. DESCRIBE NOW INJURY OCCURED marked. (Month, Day, 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is COMPLETED a Could not be DIRECTOR: 4 Homicide determined Item

2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) V4/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

20 CRUSS RUADS DRIVE OWINGS MILLS MB 21117 SUITE 210

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner ee stated.

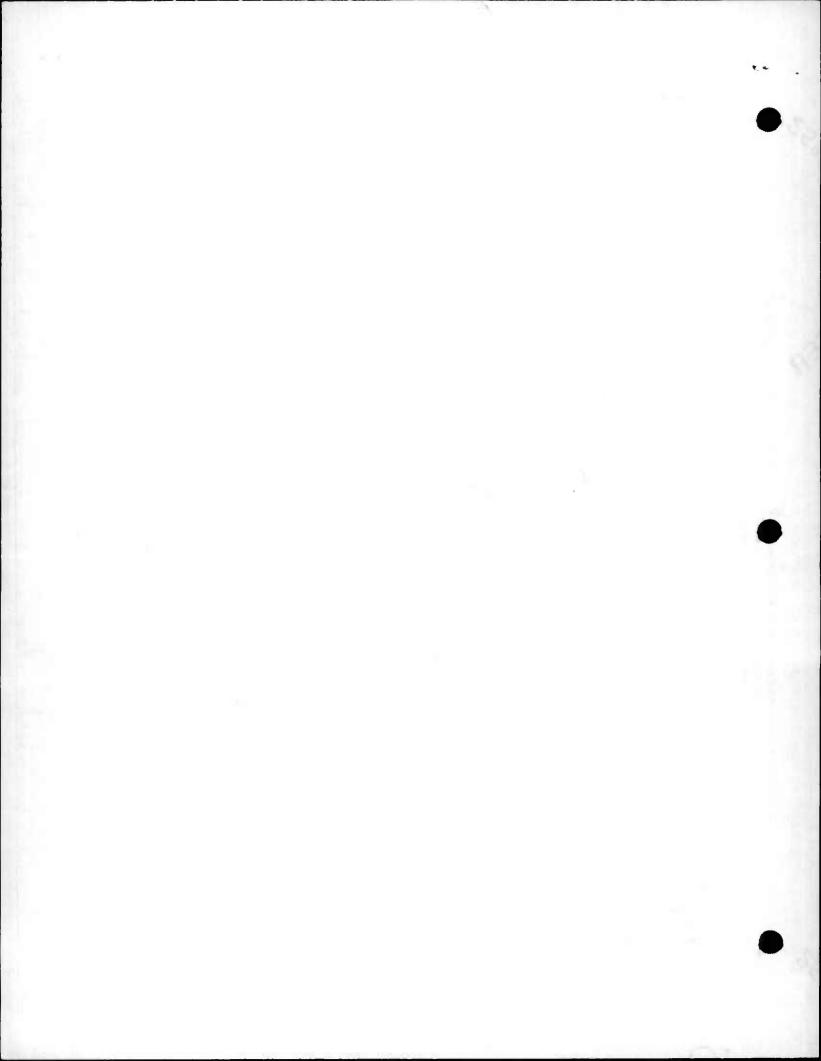
31. DATE FILEO (Month, Day, Year) 32. BEGISTRAR'S SIGNATURE 1995 APR 1

29e. CERTIFIER

HOSPITAL FUNERAL I =

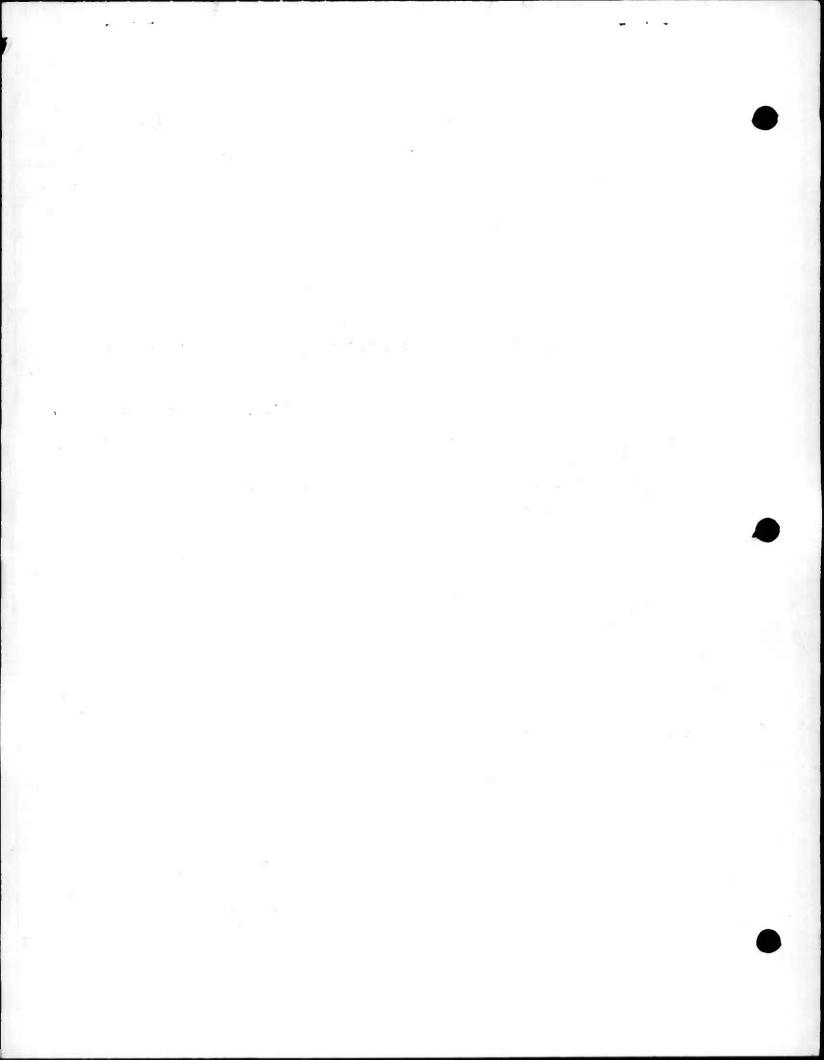
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מומיוסו מומיוסו מייני מי	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bring	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

TRECUSTIVATION TRECUSTORY		FOR	STATE OF	MADVI AND	DEDA	OTRECAL:	. 05 1	IFALTU	AND	MENTAL INVOICE	95		3819
MILTON Alexander Noon **SOON.** SOUNT PARKED 179—36—0038 **NOW!** Soon.** SOUNT PARKED 179—36—0038 **NOW!** Soon.** SOUNT PARKED 179—36—0038 **NOW!** Soon.** SOUNT PARKED 179—36—0038 **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** Soon.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOUNT PARKED **NOW!** SOON.** SOON.** SOUNT PARKED **NOW!** SOON.			SIAIE OF I	C	ERTIF	ICATE	E OF	DEA	TH				
TO SHOULD SHOULD SHOW AND THE SHOW THE				Noon						2. DATE OF OEATH MONTH April 15	DAY 19	95 ^{YEAR}	3. TIME OF OEATH 6:00 P
Millersville Home Care Severna Park Anne Arundel Maryland Dorchester No. City, Town on Location No. Precioe Severna Park No. Comment No. City, Town on Location No. Precioe Severna Park No. Comment No. City, Town on Location No. Precioe Severna Park No. Comment No. City, Town on Location No. Precioe Severna Park No. Comment No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. City, Town on Location No. Precioe Severna Park No. Precioe Severna Par										7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign y)
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16.56 Taylors Island Road 17. MANUAL DITAINS	ECT		100 00	TV TOUGL	2010047								
The process of the pr	- DIR	Maryland Do				ord		li)				10d. INSIDE CITY LIMITS? 1 YES 22 NO	
TO DESCRIPTION OF BUSINESS CONCUSTORY Secondary White the Concernment of the Concernment	VERA		d			101		_		10g. Cf		WHAT COUNTRY?	
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Mail Hotoland Alexander Noon St. S		15. DECEOENT'S ED (Specify only highest grad	JCATION completed)	(G	live kind of	work done i	CCUPATIO	ON st of working	na	16b. KIND OF B	USINESS/IN	IDUSTRY	
PART II. Other significant conditions, and significant conditions contributing to death but not resulting in death) Last Did To Cause Contributing to death but not resulting in the underlying causes given in Part I. Sequentially list conditions, and construction of cause on asch lina. Did To Cause Contributions and contributing to death but not resulting in the underlying causes given in Part I. Sequentially list conditions, and constructions contributing to death but not resulting in the underlying causes given in Part I. DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN DID TO BACCO USE	MPLE			+) life	. Do NOT u	se retired.)			•	Gene	ral P	racti	ice
THE DEPORTMENT'S NAME (Specified and Number or Paral Route Member, City or Rown, Stells, 200 ACASE AND Triplett 10 ACASE AND DATES OF SPECIFICAL PROPERTY 10 ACASE AND DATES OF SPECIFICAL PROPER	8		Noon Cr								n Sumame)		
Eleanor Noon Triplett 36. Manual Substitution 36. Manual Substitution 36. Manual Substitution 37. Manual Substitution 38. Manual Substitution 39. Manual Substituti			Noon, Si		h MAII INC	1000000							
20. METHOD OF DISPOSITION 20. METHOD OF DISPOSITION (Name of 10 Memory) 21. SIGNATURE # LIVERAL SERVICE LICENSES 22. NAME AND ADDRESS OF RACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 2161 23. PART #. Enter that diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval By constant and the service of the caused on the caused o	2		plett		464	Holly	y Fa	rms .	Rd.	Severna P.	wn, State, Z ark	Md.	21146
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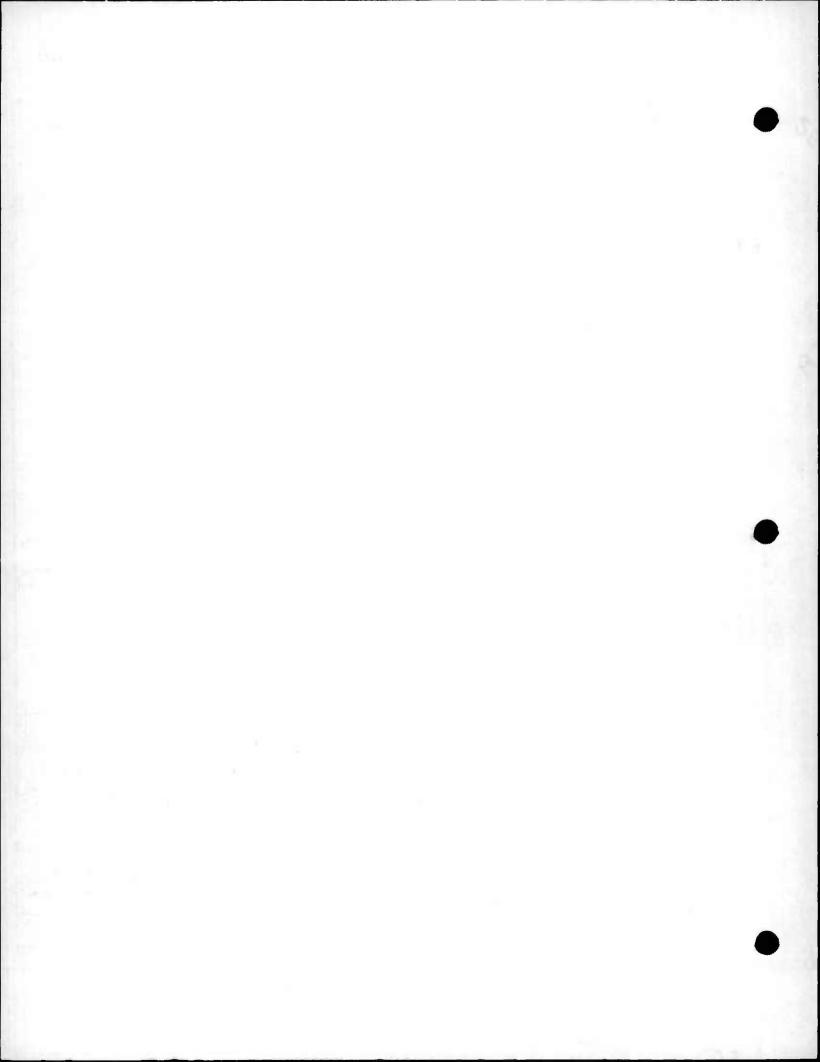


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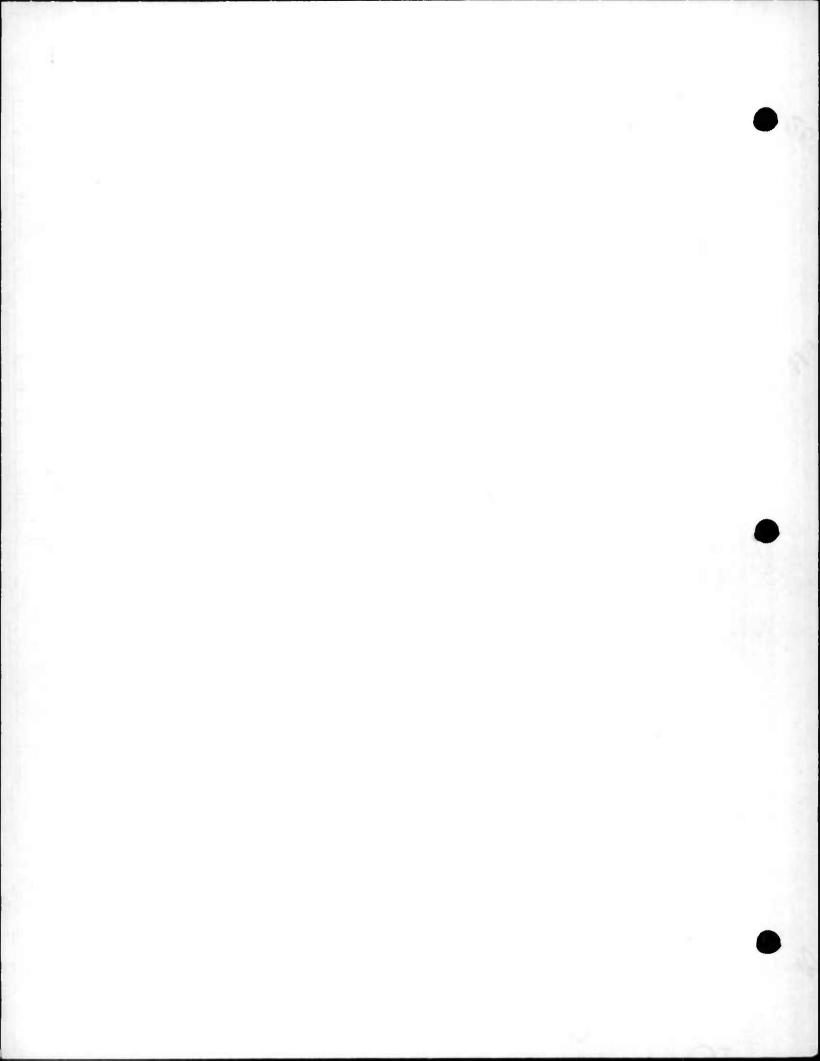
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		ENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH		
	Lulu Po	Noord	Derm.	eev~		APTIL	DAY	YEAR	1:02 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH		8. BIRTHP	Moulnein,		
	217.42.8262	1 M 2 X F 7	6 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) JAN. 19, 19	19	MYANM	MOULNEIN,		
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
8	SUBURBAN HOSPITA	L		BETHESDA				NTGOM	FDV		
[5]	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION							
DIRECTOR		MEDY						IOd. INSIDE CITY LIMITS?			
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14	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during me se retired.)	ost of working						
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COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	E (First, Middle, Maide	n Sumame)				
BE	PO				U		PO				
ဥ	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural Ro						
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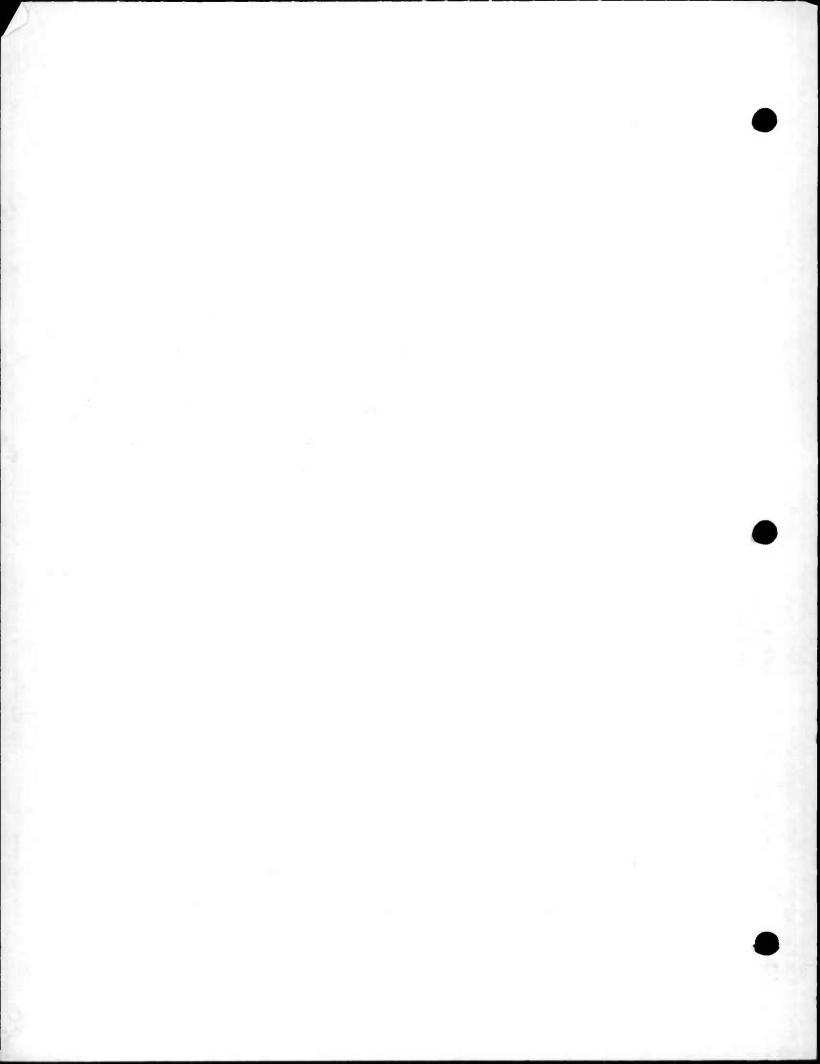
							95	13821				
	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIE						
	1. DECEDENT'S NAME (First, Middle, Last)		32/1/11	TOATE OF	DEATH	2 DATE OF BEATH		3. TIME OF DEATH				
1	LNeil		ME	KRI	CH	APTI(DAY C	YEAR 1:07A				
	4. SOCIAL SECURITY NUMBER 083-38-4387	5. SEX 8. AG	E (In yrs. lest birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 5, 1	949	8. BIRTHPLACE (State or Foreign Country) NEW YORK				
H.	99. FACILITY NAME (If not institution, give montgomery general				OR LOCATION OF O		9c. COUN	NTY OF DEATH				
1 5	RESIDENCE OF DECEDENT				MILI .		MON	TGOMERY				
DIRECTOR		NTGOMERY	10c. CIT	BROOKEV	10d. INSIDE CITY LIMITS? 1 YES 2 NO							
FUNERAL	100. STREET AND NUMBER 19440 JAMES CRE	EK COURT		10	1. ZIP CODE 20833		-	ZEN OF WHAT COUNTRY?				
NE NE	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ADMEO	12 140 05		NIC ORIGIN? (Specify Y		TED STATES				
M ≥	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YE	8 2 X NO	If yes, s	Decify Cuban, Mexico 3 2 X NO Speci	es or No—	14. RACE — American Indian, Black, White, etc. Specify: WHITE					
9	15. OECEDENT'S EOU (Specify only highest grade	CATION	16a. OECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BI	JSINESS/INOI					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during m se retired.) ON MANAG		INSUF	RANCE					
BE CO	17. FATHER'S NAME (First, Middle, List) 1 RVING NEKRICH 18. MOTHER'S NAME (First, Middle, Melden Surrame) LEE KALKSTEIN											
TO B	19a. INFORMANT'S NAME (Type/Print) DENISE NEKRICH 19b. MAILINO ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 19440 JAMES CREEK COURT—BROOKEVILLE, MARYLAND 208											
	20g. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of control of the control o											
	4 Donation 5 Other (Specify)		EW MONTE				NELAW	N, NEW YORK				
	+ Harr	Tr. YI	se	DANZA 1170	ROCKVILL	DBERG MEMO E PIKE-ROC	KVILL	CHAPELS, INC. E,MD. 20852				
	IMMEDIATE CAUSE (Finel	complications that cause on list only one cause on	aach lina.	not enter the me	ode of dying, aud	ch ea cerdiac or resp	piratory erre	est, Approximata interval Between Onset and Deatl				
ı	disease or condition resulting in death)	S. DUE TO (OR AS	A CONSEQUENCE O		ore t	De	ase I year					
ATION	Sequentisity list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
CE		d										
MEDICAL	PART II. Other significant condition	ns contributing to deeth	but not resulting	in tha underlyin	g ceuse givan in		RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE				
ME								OF DEATH?				
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE			UNCERTAI	N 🗆 📗						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:								
HYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Ou 26a. DATE OF INJURY	26b. TIM	E OF 28c, IN.	NO 5 Residence	6 ☐ Other (Specify) 28d. DE\$CRIBE HOW	INTILIBA OCCI	IIPED				
ВУ Р	1° Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INI	M 1	PRK? YES 2 NO	200. DEGOTION HOW		UNED				
TED	3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJUI building, atc. (Sp	tY — At home, farm, recify)	street, factory, offic	•	28f. LOCATION (Street City or Town, State	and Number o	or Rural Route Number,				
COMPLETED		CIAN: To the best of my kno						d. cause(s) and manner as stated.				
ECC	29b. SIONATURE AND TITLE OF CERTIFIE		en le nemero									
00	29G. LICENSE NUMBER 29d. DATE SIGNEO (Month.)											
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D			Scon	SIN A	ive	Botto				
	APR 18 1995	Julia d'audio										



DIVISION OF VITAL RECORDS, P.O. BOX 68/60	BALTIMORE, MARYLAND 21215-0020
TO THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within: 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the face fluctuations of the following the followin	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 20 bears dear death with the Case Dear of Health and Mariah Hullians page 1, 2, 3 should
De med whom is though an ended with the case begin in reason and mental system prior begins the market as an end to case the market is a case of the market	manding avancings sound by saiding of as seen

Martin C. Shargel, 31. OATE FILEO (Month, Day, Ybar) APR 18 1995

	1	FOR STATE REGISTRAR	STATE OF I	MARYLAND /		TMENT OF			MENTAL	HYGIENI REG. NO.	est.	5	10022	
		1. DECEDENT'S NAME (First, Middle, Last) MILDRED	NEWC	NEWCOMB				2. DATE OF DEATH DAY APRIL 16, 1995 5:50						
		4. SOCIAL SECURITY NUMBER 091-05-6221	5. SEX 1 M 2 X F	6. AGE (In yrs. Ia:					7. DATE OF BIRTH (Month, Day, Year) June 16, 1904 New York					
TOR	- 10	9a. FACILITY NAME (If not institution, give a Circle Manor Nur RESIDENCE OF DECEDENT	ter	9b. CITY, TOWN OR LOCATION OF OR Kensington				eath sc. county of Montgo						
E	1	10a. STATE 10b. COUNT		10c. CITY, TOWN OR LOCATION						10d, INSIDE CITY				
BY FUNERAL DIRECTOR	1	Maryland Mont 10e. STREET AND NUMBER		Kensington						LIMITS? 1 X YES 2 NO WHAT COUNTRY?				
E S		10231 Carroll Pl	ace				20	895			Un:	ited	States	
l S	1	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. WAS	DECENDENT (OF HISPAN	IIC ORIGIN	7 (Specify Yes		14. BAC	E — American Indian.	
	- 10	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE V	YES 2X	NO		, specify Cubi YE\$ 2X NO		en, Puerto Rican, etc.) Bisc			Spec	ck, white, etc. White White	
1 1 1		15. DECEDENT'S EDU (Specify only highest grade	completed)	(G	him kind of	USUAL OCCUP	ATION most of working	ng	16b.	KIND OF BUS	INESS/IN	DUSTRY		
COMPLETED	L	Elementary/Secondary (0-12)	College (1-4 or 5	+)	(Give kind of work done during most of working life. Do NOT use retired.) Housewife					Own Home				
TO BE COM			fferson		ird		Ju:	lienr	ne	liddle, Maiden :		Rodgers		
100	L	Bazil W. Brown,	Jr. (So			New Har							on, DC 20037	
E E	1	20a. METHOD OF DISPOSITION 1		cemetery, cre	ematory or o	of disposition ther place) ke Cren			4-1	7 Belt			own, State	
examiner	ľ	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A.												
		M00827 933 Gist Ave, Silver Spring, MD 20910												
		23. PART/I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):												
ill, ill	1 4	disease or condition .	a. ASPIRA	TION PNE	UMON	IA						1631,	Interval Between Onset and Death	
SERTIFICATION	s in	disease or condition .	DUE TO	TION PNE	EUMON OUENCE O CA	IA P):					wildly at		Interval Between Onset and Death	
MEDICAL CERTIFICATION		disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa reaulting in death) LAST	DUE TO B. SEVERE DUE TO C. DUE TO d	TION PNE (OR AS A CONSECUTION OF AS A CONSECUT	OUENCE O	TA F): F): In the underly	ying cause (24e. WAS AN / PERFORI 1 YES 2	AUTOPSY MED?		Interval Between Onaet and Death One Week	
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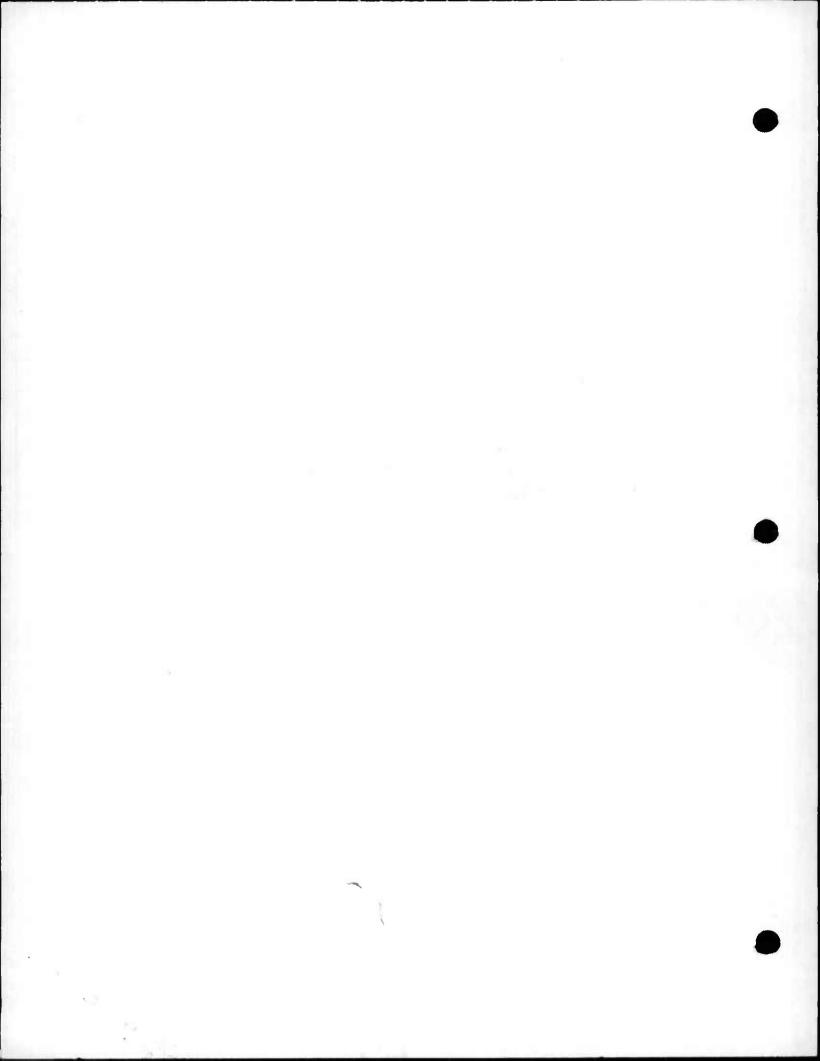
BALTIMORE, MARYLAND 21215-0020

cal examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
y are removed uncount, peage 3 smooth De detached not noval.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
y the funeral director, page 5 should be detached for	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for
after death. Page 6 may be retained by the hospital of	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital of

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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	ITMEN	T OF H	EALTH DEAT	AND I	MENTAL	HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Las	t)								OF DEATH		3	. TIME OF DEATH
	Beauveau B	. Nalle							April 18, 1995			YEAR .	1548 _M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lesi	birthday)		UNDER 1 YEAR IF UNDER 24 HRS.		24 HRS.	7 DATE OF BURTH		8. BIRTHPL	ACE (State or Foreign	
	185.20.4776	1 🔀 M 2 🗆 F	68	YAS.	MONTHS	MONTHS DAYS HOURS MIN.			Feb. 17, 1927 Per			enns	ylvania
	Sa. FACILITY NAME (If not institution, give	street and number)			9b. CIT	CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY					TY OF DEA	тн	
DIRECTOR	Suburban Hospita		Bethesda						Mo	mery			
ᇤ		10b. COUNTY					100						
<u> </u>		y, town or location Thevy Chase							Od. INSIDE CITY LIMITS?				
	Maryalnd Mon	tgomery			nevy		. ZIP CODI		10g. CITIZEN OF WH				YES 2 NO
FUNERAL	4204 Maple Terr	200					0815	_					AT COUNTRY?
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	11. MARITAL STATUS		IT EVER IN U.S. ARI	AFD	12				U.S.A.				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	□XYES 2 □N WAR OR DATES WWII			If yee, spe	2 NO	n. Mexice	n. Puerto P	licen, atc.)	or No.	Black, Specify:	- American Indian, White, atc. White
COMPLETED	16. DECEDENT'S EE (Specify only highest gra	DUCATION de completed)	16e. DEC	CEDENT'S	USUAL O	CCUPATIO	ON st of workin	v7	16b.	KIND OF BUS	BINESS/INDL	ISTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 8	•)				st of workin						
MP		5+	Fore	ign	Serv	ice	Offi	cer	S	tate D	epart	ment	
	17. FATHER'S NAME (First, Middle, Last)									liddle, Meiden	Surneme)		-
BE	Albert Nalle								у Во:				
5	180. INFORMANT'S NAME (Type/Print) Elizabeth Nalle									or, City or Town		Code)	
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of												
	A Donation 6 Other (Specify) Rock Creek Cemetery 4/22 Washington D.C.												
	22. NAME AND ADDRESS OF FACILITY JOSEPH Gawler's Sons 5130 WI AVE NW WASHINGTON DC 20016												
	* Keinon	Sew	mox		5	130	WI A	VE N	W WA	SHINGT	ON DC	200	16
	23. PART I. Enter the diseases, or complications that caused the desth. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart feliure. List only one cause on each line.												
	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	a. Putra cerebral Bleed									Interval Between Onset and Death		
z	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSEC	UENCE OF	Fi.		n'in	1					
E	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS CONSEC	UENCE OI	Pi:	My				 -			
F	resulting in death) LAST	d											
2	Direction of the second of the												
MEDICAL	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE										AILABLE PRIOR TO		
W									- 1			1	YES 2 NO
ä	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEAT	H YE	S 🔲 I	NO 🗆	UNC	ERTAIN	4 D				200
¥ S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEAT									
Si	1 YES 2 NO	HOSPITAL:	ER/Outpetlant 3	□ DOA	4 Nur		6 🗆 Re:	sidence	6 🗆 Other	(Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF (Month, D		28b. TIM	E OF URY	28c. INJU	JRY AT		26d. DEŞ	CRIBE HOW IN	UURY OCCL	PED	
ВУ	1 Natural 5 Pending 2 Accident Investigation		-,, , , , , , , , , , , , , , , , , , ,		М		ES 2) NO					
	3 Suicide 6 Could not b 4 Homicide Setermined	28e. PLACE 0 building,	F INJURY — At hometc. (Specify)	10, ferm, s	street, fact	lory, offica			281. LOCA City o	TION (Street a. r Town, State)	nd Number o	r Rural Rou	te Number,
COMPLETED		SICIAN: To the best of											
8	2 MEDICAL EXAMI		camination and/or in	veatigatio	n, In my c	pinion, de	ath occur	ed at the t	time, data	and placa, and	due to the	cause(a) a	nd menner se stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFI	ER					29c. LICE	NSE NUM	BER		29d. DATE		onth, Day, Year)
2	GUA UNA	111871	a de	2			08	13/	70		HP	RIL	19,95
- 1	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	E OF DEATH (ITEM	27) (Type,	Print)								

M.D. 9406 Old Georgetown Rd. Bethesda, Md. 20814-1722

Gita Chopra Bakshi, 31. DATE FILED (Morith, Day, Yoar) APR 21 1995



BAL	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Jath certificate be executed within 12 hours after death	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the tending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Men Wigiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury or . See traumatic event, the medical exam
	hours a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the tending physician and completely filled in by the fut be filled within 72 hours after death with the State Dept. of Health and Men. "Avgliene prior to burial, cremation, or removal."	medic
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DIVISION OF VITAL AECORDS, P.O. BOX 88/80	tificate	phys	Yer.
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Dpinder Singh,
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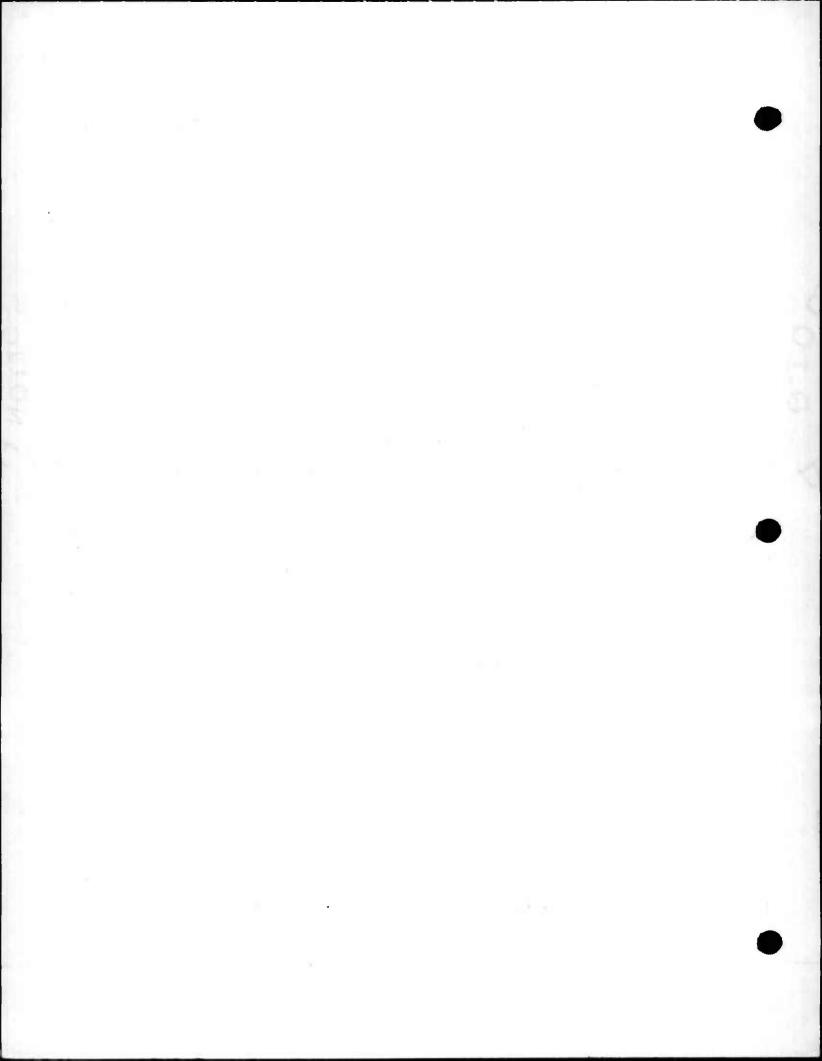
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	1 - FOR STATE REGISTRAR	STATE OF M				F HEALTH		MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEA			3. TIME OF DEATH
									DAY	YEAR	0.54
		SEX	8. AGE (In yrs. i	not hirthday)	IF UNDER 1 YE	AR IF UNDER	04 1800	April 1		_	
		□ M 2 🖾 F	100.00	-101	MONTHS DA		MIN.	(Month Day Ve	ar)	Count	
1	210-33-3030		64	, Tha.				Dec. 31	, 1930	Vie	etnam
l ~	96. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 70. COUNTY OF DEATH									DEATH	
Ö	Doctor's Hospital			Lanh	.am			Georges			
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		100 00	Y, TOWN OR L	20471011						
DIRECTOR	Maryland Montgon						10d. INSIDE CITY LIMITS?				
	100. STREET AND NUMBER	пету		511	ver Sp					1 A YES 2 NO	
A A	9628 Cottrell Terra					10f. ZIP CODI					WHAT COUNTRY?
FUNERAL						2090	3		V:	ietna	ım
5	11. MARITAL STATUS 12 1 Never Merried 2 Married	FORCES? 1	YES 2 K	RMED	13. WAS	DECENDENT O	F HISPAN	IC ORIGIN? (Speci	fy Yea or No-	14. RAC	E — American Indian, ck, White, etc.
Æ	3 X Widowed 4 Divorced	IF YES, GIVE W				YES 2 NO			-)	Şçeç	letnamese
											Letnamese
1	15. DECEDENT'S EDUCATI (Specify only highest grade com	npleted)	16a, E	Give kind of	USUAL OCCUI	PATION g most of working	g	18b, KIND O	F BUSINESS/II	DUSTRY	
1 5		College (1-4 or 5+)									
COMPLETED	12			Home	maker				vn Home		
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTE	HER'S NAI	WE (First, Middle, M	elden Surname)		
H	Nhung Nguyen						ieu				
2	19e. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS (Str	eet and Number	or Rural F	loute Number, City o	v Town, State, 2	(ip Code)	
	Hung To		1	500 C	akview	Drive	, Si	lver Sp	ring,	Mary1	land 20903
	20a. METHOD OF DISPOSITION 1 Burlel 2 X Cremation 3 Removal	from State	20h PLACI	ANODATE	DE DISPOSITIO	M/Mama of		DATE 20	c. LOCATION -		
	4 Donation 8 Other (Specify)		Fort	Linc	oIn Cr	emator	У	4/17 B ₁	centwoo	od. M	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			22. NAM	E AND ADDRES	S OF FAC	Hines	-Rinal	di Fu	uneral Home
11800 New Hampshire Avenue											
	22 BADY Enter the diseased or saw	Miles									
	23. PART . Enter the diseases or com ahock, or heart failure. List	only ona ceus	e on aach lir	ieath. Do i ia.	not anter the	mode of dyl	ng, such	aa cardiac or	respiratory e	rrest,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition									Onset and Death	
	reaulting in death)		orrhagi								1 day
			OR AS A CONS	_	,						
Z	Acquestially list annihilana	Dis	semina	ted :	Intera	rascula	vr (Coaqulat	ion		1 dau
ATION	equantially list conditions, Disseminated Interavascular Coagulation DUE TO (OR AS A CONSEQUENCE OF):										
17	Anna F.A. INDENIMA									1 day	
1 =	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	OUENCE O	F):						
CERTIF	d										
	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS										
PHYSICIAN: MEDICAL				. saering	tro urrual:	And canse &	pre-1111		S AN AUTOPSY RFORMED?	246	MAILABLE PRIOR TO
i i	Hepatocellular Carcinoma 1 □ YES 2 7 NO								COMPLETION OF CAUSE OF DEATH?		
Σ								_			1 TES 2 NO
z	DID TOBACCO USE CONTRIB	UTE TO CAL					ERTAIN				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OŞPITAL:	26. PLJ	CE OF DEA	H (Check only	one)					
YS.	T YES 2 NO 1	Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER:	Home 5 🗆 Re	sidence	8 Other (Specify)		
표	27. MANNER OF DEATH	28e. DATE OF II (Month, Day		28b. TIM	E OF 28c.	INJURY AT WORK?		28d. DEŞCRIBE H	OW INJURY OF	CCURED	
B	1 Natural 5 Pending 2 Accident Investigation					YES 2	NO				
	3 Suicide 8 Could not be	28e. PLACE OF building, e	INJURY — At h	ome, ferm,	treet, factory,	office		281. LOCATION (S.	treet end Numbe	or or Rural I	Route Number,
	4 Homicide determined							ony or lown,			
COMPLETED	29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN	i: To the best of n	ny knowledge. d	eath occum	d at the time	date end place	and due	to the causele) en	menner so st	ntad	
M	one) 2 MEDICAL EXAMINER: 0										e) and menner ee stated
	296. SIGNATURE AND TITLE OF CERTIFIER		0								
BE	Robudas	Sing	K M	D			NSE NUM				(Month, Day, Year)
2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							pril	14, 1995			
	I JU. RAWE AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE	OF DEATH OT	EM 27) (Time	Drine)						

3060 Mitchellville Rd.

32. REGISTRAN'S SIGNATURE

Daucher Parael

Bowie, MD



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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

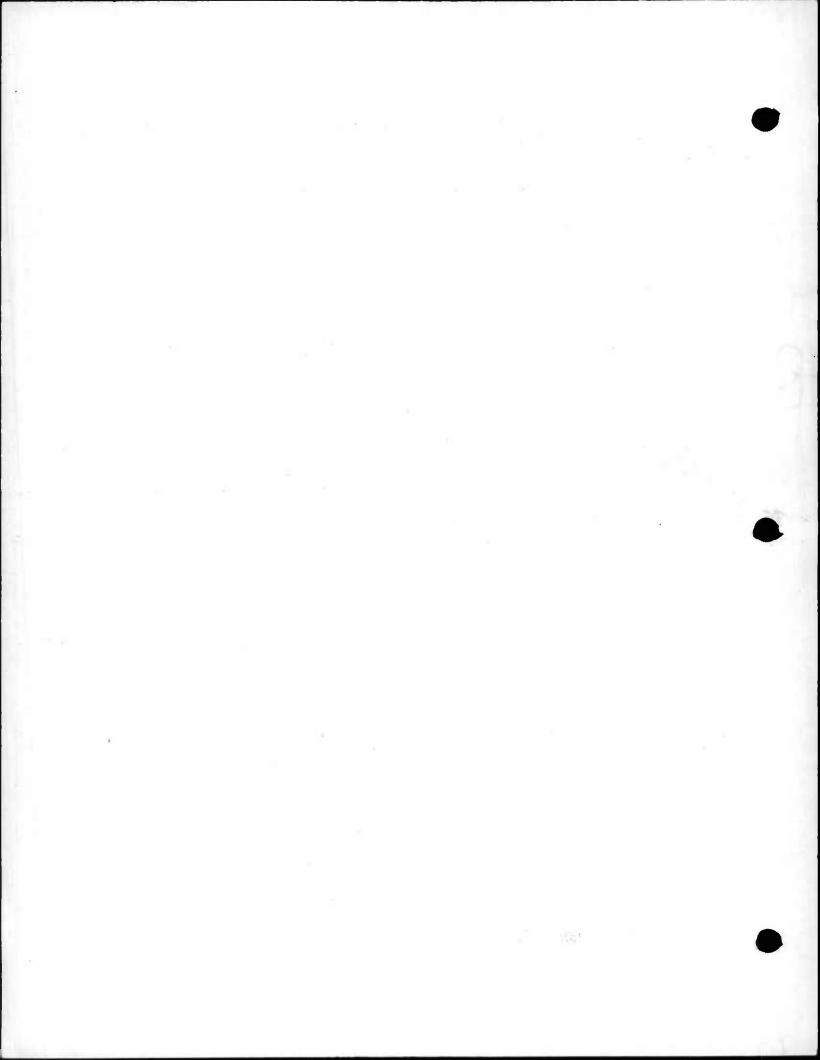
6 1995

32. REGISTRAR'S SIGNATURE

RSON Tower 110 600

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY SANDRA NEAL Kay APRIL 20. 1995 11:10A 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) B. BIRTHPLACE (State or Foreign 1 M 2 F 219-66-2024 July 19,1956 Germany the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Smithsburg 1 - YES 2 - NO FUNERAL 10e. STREET AND NUMBER 10f 71P CODE 10g. CITIZEN OF WHAT COUNTRY? 14159 Tower Road 21783 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.)
1 □ YES 2√ NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES B₹ Specify: 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION BE COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Owner / Operator Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Derward Eva<u>lena</u> Davis G. Hemrick 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Stanley Robert Neal 14159 Tower Road Smithsburg, Maryland pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) DATE must Rose Hill Cemetery 4–25–1995 Hagerstown, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home Muclas 1331 Eastern Blvd. N. Hagerstown Md 21742 event, the medical 23. PARTI. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. been signed by the attending physician and completely filled in by of the lith and Mental Hygiene prior to burial, cremation, or remo Approximata Interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) Short TO (OR AS A CONSEQUENCE OF): 24 hour other traumatic CERTIFICATION Sequentially list conditions, DUE TO JOB AS A CONSEQUENCE OF if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 20 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE bone namow transplant for breast cause requires that any YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VUNCERTAIN PHYSICIAN: this certificate has be with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending Investigation TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After thi be filed within 72 hours after death w IMPORTANT: If Item 28 is mark 1 YES 2 NO ВҮ A Coldent 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER (Check only one) 1) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Endos AOU, M.D Mess

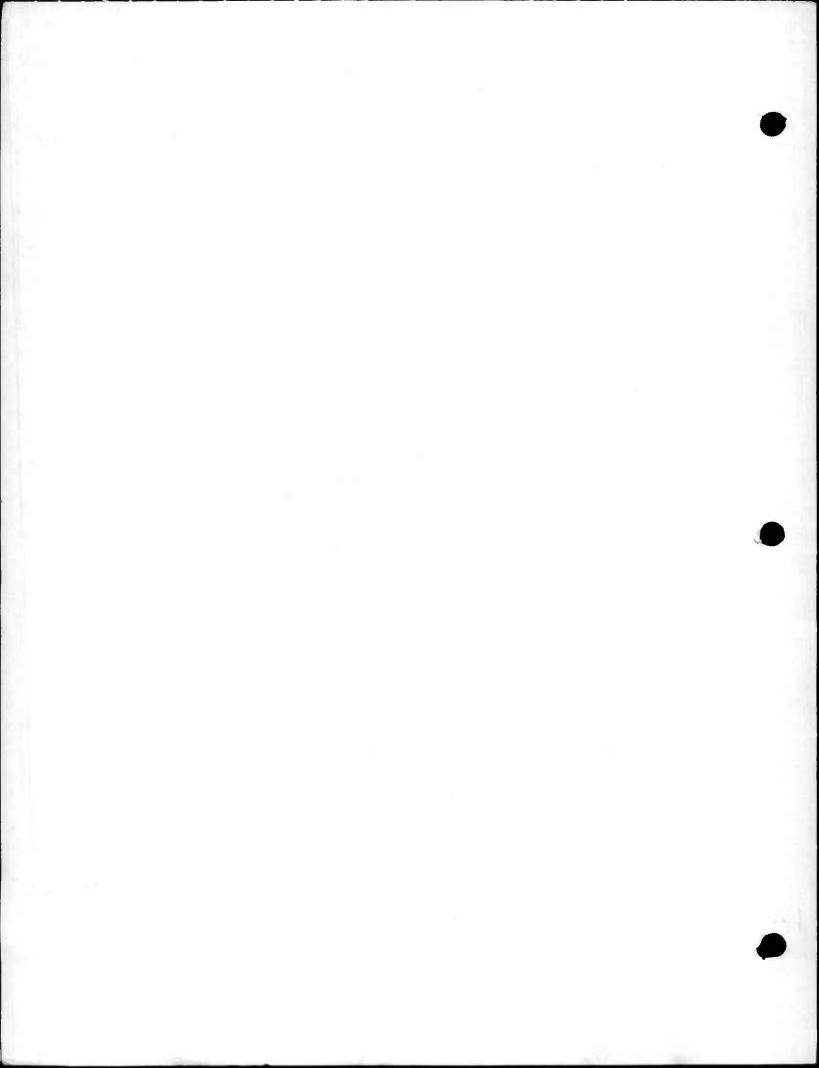
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permit. Pages 1, 2, 3 should

mended # 29 d # //1/95 MRT MATTER STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Helen 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday 7. DATE OF BIRTH 1911 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State of Foreign 1 M 2 F DAYS 269-12-0035 84 March 13 Ohio 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Collingswood Nursing Center Rockville Montgomery RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 10110 New Hampshire Avenue 20903 U.S.A 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 11 Factory Worker Tire and Rubber 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Hallinan BE Martha Sibert 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ellen O. Woods 907 Langley Drive Silver Spring, Maryland 20901 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Gate of Heaven Cemetery 4/14/95 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE AF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. teven 500 University Blvd., W. Sil.Spr., MD 20901 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): I arterio & Servite heart disease lyumater) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY seal alteria 1 TYES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: ient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending 1 YES 2 NO BY 3 Sulcide 28a. PLACE OF INJURY — At homa, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pieca, and due to the cause(a) end menner as stated. MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, D00946 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON wilfred R. Ehrmantraut, M.D. 11125 Rockville Pike #103, Rockville, MD 20852 31. DATE FILED (Month, Day, Year) 22. REGISTRAD'S SIGNATURE



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

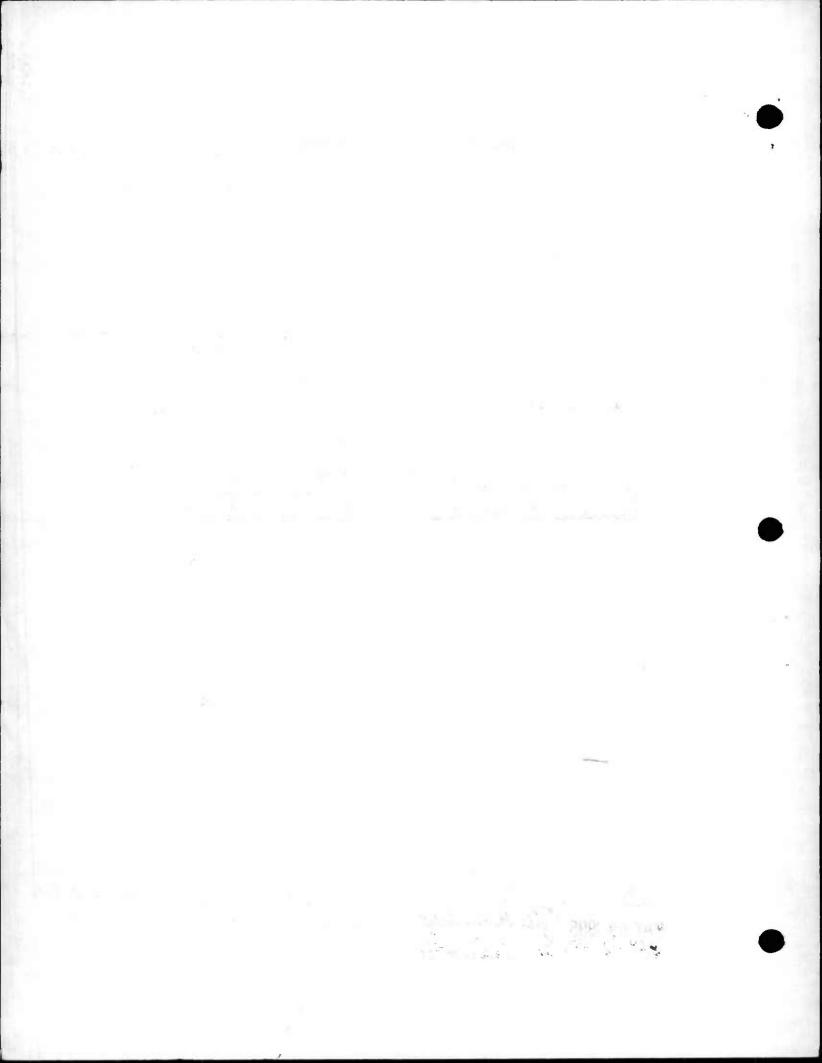
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

, A	REGISTRAR		CENTI	FICALE C	F DEATH	RE	G. NO.						
	1. DECEDENT'S NAME (First, Middle, Last) DAVID CH	RISTOPHER	?	os	BORNE	2. DATE OF DE MONTH APRIL	27	95 3. TIME OF GEATH					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. lest birthda	y) IF UNDER 1 YEA		_							
i	212-80-1810	1 📉 M 2 🗌 F	26 YRS	MONTHS DAY		7. DATE OF BIF (Month, Day, Aug. 6,	Year)	8. BIRTHPLACE (State or Foreig Country) Maryland					
DIRECTOR	90. FACILITY NAME (If not Institution, give street and number) 253 BRIDGE STREET 90. CITY, TOWN OR LOCATION OF DEATH ELKTON CECIL												
5	RESIDENCE OF DECEDENT												
#	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION												
	Maryland Cecil		E1	kton				LIMITS?					
₹	10e. STREET AND NUMBER				101. ZIP CODE		10g. CIT	IZEN OF WHAT COUNTRY?					
	136 McCleary Road 21921 U.S.A.												
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Spe	cify Yea or No-	14. RACE — American Indian, Black, White, etc.					
ā	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YE	DATES 2 KINO		specify Cuben, Mexic (ES 2X NO Speci		etc.)	Specify: White					
3	15. OECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDENT	'S USUAL OCCUP	ATION	16b. KINO	OF BUSINESS/INC	DUSTRY					
	Elementary/Secondary (0-12)	College (1-4 or 5+)	iile. Do NOT	of work done during use retired.)	most of working								
	12		Mainte	nance A	prentice	Indu	strial						
COMPL	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle,							
	Roger Donal	ld Osborne					n Brook	c					
	19a. INFORMANT'S NAME (Type/Print)	-	19b MAII II	NG ADDRESS /See	et and Number or Rural								
2	Mary Ann Baker				Road - I								
	20e. METHOD QE DISPOSITION	Ι.											
	1 Burial 2 N Cremation 3 Ramon	vet from State	Ob. PLACE AND OAT	r other place)	(Name of	4-29		City or Town, State					
	4 Donation 5 Other (Specify) R.A. Ferris & Company Hoor West Chester												
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. WAME AND ADDRESS OF FACILITY HICKS HOME for Funerals, P.A. 103 West Stockton Street												
	Donald S. Hubs 103 West Stockton Street Elkton MD 21921-5521												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
	that initiated events resulting in death) LAST d												
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Psrt i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WE 2 NO 24c. WAS AN AUTOPSY PERFORMED? AM CO OF												
	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH	ES NO	☐ UNCERTAI	N 🗆							
; III	25. WAS CASE REFERRED TO MEDICAL	HORDITAL	26. PLACE OF DE	ATH (Check only o	ne)								
	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 XFM sidence 6 Other (Specify)											
	EXAMINER?		repetient 3 1 DOX	27, MANNER OF DEATH 28s. DATE OF INJURY 28s. TIME OF 28c. INJURY AT 28d. DESCRIBE									
	EXAMINER? ** YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou 28a. DATE OF INJURY			INJURY AT	28d. DESCRIBE	HOW INJURY OC	CURED					
	EXAMINER? 1 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Ou 28a, DATE OF thJURN (Month, Day, Year)	r²0uT	ME OF 28c.	NJURY AT WORK? YES 2 NO		ter salityoon at	CURED					
	EXAMINER? 2 NO 27. MANNER OF DEATH 1 Natural 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) FOUND 4-27- 28a. PLACE OF INJURY	-95 8:0	IME OF 28c. NJURY T	WORK? YES 2 NO	UNKNOW	N Street and Number	or Rural Route Number.					
	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural Fending 2 Accident Investigation	1 Inpetient 2 ER/Ou 28a. DATE OF INJURY (Month, Day, Year) FOUND 4-27-	-95 8:0	ME OF 28c. NJURY T O A ^M 1 [o, atreet, factory, o	WORK? YES 2 NO	UNKNOW 281, LOCATION City or Town	(Street and Number , State) 253 BI	or Rural Route Number.					
	EXAMINER? 27. MANNER OF DEATH 1 Netural 2 Accident investigation 3 Suicide 8 X Could not be determined	28a. DATE OF tHJURY (Month, Day, Year) FOUND 4-27. 28a. PLACE OF INJURY building, etc. (Sp	-95 8:0 8:0 8:0 FOU!	ME OF 28c. NJURY T O A ^M 1 [o, atreet, factory, o	WORK? YES ZXX NO	UNKNOW 281. LOCATION (City or Town ELKTON,	N (Street and Number , State) 253 BI MARYLAND	or Rural Route Number,					
. 11	EXAMINER? 27. MANNER OF DEATH 1	28a. DATE OF tHJURN (Month, Day, Year) FOUND 4-27 28a. PLACE OF INJUR building, etc. (Sp	95 8:01 Y — At home, term ecify) FOUL	ME OF 28c. NJURY T 0 A ^M 1 [1, street, factory, o 1D AT HOME	WORK? YES 2 NO Hiles ete and place, and due	UNKNOW: 281. LOCATION City or Town ELKTON,	N (Street and Number, , State) 253 BI MARYLAND and manner as stat	or Rural Route Number, RIDGE ST.					
	EXAMINER? 27. MANNER OF DEATH 1	28a. DATE OF tHJURN (Month, Day, Year) FOUND 4-27 28a. PLACE OF INJUR building, etc. (Sp	95 8:01 Y — At home, term ecify) FOUL	ME OF 28c. NJURY T 0 A ^M 1 [1, street, factory, o 1D AT HOME	WORK? YES 2 NO Iffice ate and place, and due to death occured at the	UNKNOW: 281. LOCATION. City or Town ELKTON, to the cause(e) at time, data and pl.	N (Street and Number, State) 253 BI MARYLAND and manner as state ace, and dus to the	or Rural Route Number, RIDGE ST . ted.					
	27. MANNER OF DEATH 1	28a. DATE OF tNJURY (Month, Day, Year) FOUND 4-27- 28a. PLACE OF INJURY building, etc. (Sp. AN: To the best of my knoon the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of the control	95 8:01 8:01 Y — At home, term ecity) FOUI	ME OF 28c. NJURY T 0 A ^M 1 [1, street, factory, o 1D AT HOME	WORK? YES 2 NO Iffice afte and place, and due to, death occured at the	UNKNOW: 281. LOCATION of the Course of the cause(e) at time, data and pl. MBER	N (Street and Number, State) 253 BI MARYLAND and manner as state ace, and dus to the	or Rural Route Number, RIDGE ST. ted. ne ceuse(a) and manner as state. E SIGNED (Month, Day, Year)					
	EXAMINER? 2. ACIDENT 1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	28a. DATE OF tNJURY (Month, Day, Year) 28a. DATE OF tNJURY (Month, Day, Year) FOUND 4-27- 28a. PLACE OF INJUR building, etc. (Sp AN: To the best of my kno On the basis of examinati	95 8:01 8:01 Y — At home, term ecify) FOUI wiedge, death occur on end/or investigat	ME OF T 28c. O AM 1 [o, street, factory, o ID AT HOME rred at the time, d tion, in my opintor	WORK? YES 2 NO Iffice afte and place, and due to, death occured at the	UNKNOW: 281. LOCATION. City or Town ELKTON, to the cause(e) at time, data and pl.	N (Street and Number, State) 253 BI MARYLAND and manner as state ace, and dus to the	or Rural Route Number, RIDGE ST . ted.					

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dent. of Health and Mental Hydrene prior to hursal, cremation, or removal **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-18 Ray 1/89



BOX 68760 DIVISION OF VITAL RECORDS, P.O.

Pages 1, 2, 3 should permit. hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit I. notified at pe must examiner filled in by the fi on, or removal. medical 9 cremation, traumatic event, the completely executed within signed by the attending physician and com Health and Mental Hygiene prior to burial. OR ATTENDING PHYSICIAN: The law requires that the death certificate be other 6 any shows a t. of h has be Dept. c 23 certificate h 0 marked, this c After t 28 Is DIRECTOR: / Item THE HOSPITAL C THE FUNERAL D filed within 72 ho TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II

ITEMS: 23 PART I, 27. PER MEO FILM G-723 5/30/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 20, SHAUNA OSBOURNE 1995 LYNNE 8:17 ам 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Oct 10, 212-86-5669 1 - M 2 XF 22 1972 PA 9a. FACILITY NAME (If not institution, give efreet end number 9b. CITY, TOWN OR LOCATION OF GEATH 9c COUNTY OF OFATH DIRECTOR MEMORIAL HOSPITAL ALLEGANY CUMBERLAND RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Allegany Cumberland 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f ZIR CODE 10g, CITIZEN OF WHAT COUNTRY? USA 5C Fort Cumberland Homes 21502 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO IF YES, OIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puerto Rican, atc.)
 I YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried ВҰ Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Clerk Retail Dept. Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Norman L. Osbourne, Jr. BE Peggy Ann (Dyche) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Peggy A. Osbourne 224 Baltimore Avenue; Cumberland, MD 20a METHOD OF DISPOSITION
1 Duriat 2 Cremation 3 F
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c, LOCATION — City or Town, State OATE Sunset Memorial Park 04/24 Cumberland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home ame Cumberland, MD 21502 23. PART i/Enter the diseases, or complications that dused the death. Do not enter the mode of dying, such as cerdisc or respiratory streat, Approximate shock, or heart failure. Liet only one cause on each line interval Retw IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CARDIOMYOPATHY OF PREGNANCY OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 PYES 2 | NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2X|XR/Outpatient 3 | DOA OTHER: XXVES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 XXMEDICAL EXAMINER: On the basis of axa stion and/or investigation, in my opinion, death occured at the time, date end placa, end due to the ceuse(e) and menner as stated. 29b. SIGNATURE AND THELE OF CERTIFIED BE 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) APRIL 21, 1995 O.C.M.E. 0

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

01 1995

32. REGISTRAR'S SIGNATURE

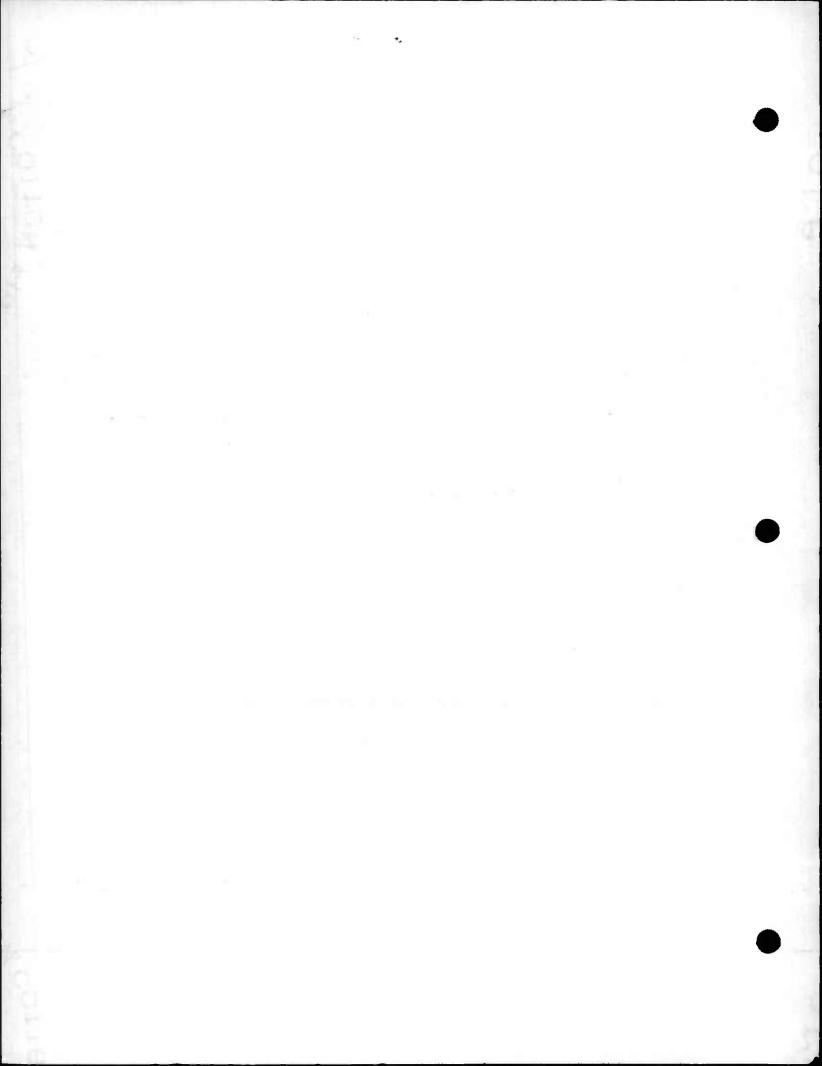
OHMH-16 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

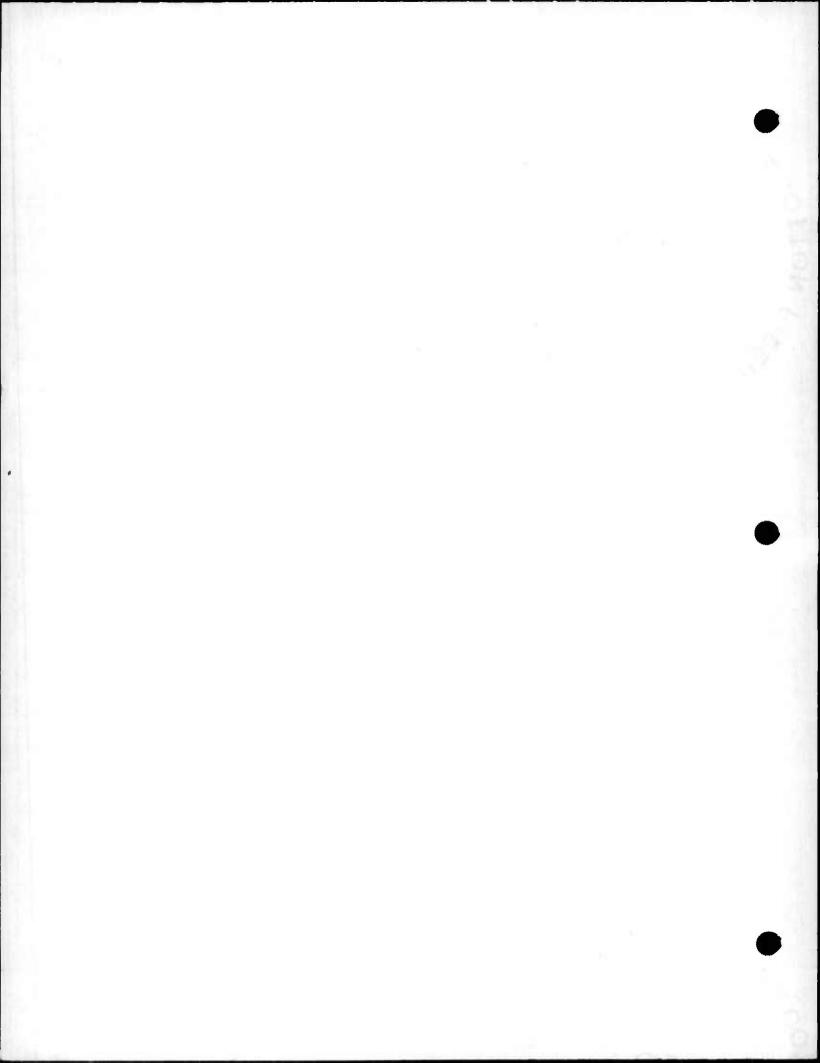
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BALTIMORE, MARYLAND 21215-00	scuted within 24 hours after death. Page 6 may be retained by the hospital or attending of
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FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	IYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN	AY YEA	3. TIME OF DEATN			
		August 4. social security number	Joseph		wick		April 21	,1995	3:00 AM M			
Pa		216-01-4632	1 _¥ M 2 □ F 92	In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) July 18,	1902 m	athplace (State or Foreign untry) aryland			
2, 3 should	стоя	90. FACILITY NAME (If not institution, give st 903 Long Bar Harb RESIDENCE OF DECEDENT			Abingd	OR LOCATION OF DI	EATN	9c. COUNTY O				
. Pages 1,	DIREC	100. STATE 100. COUNTY Maryland Harfor	·d		ngdon	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
permit.		10e. STREET AND NUMBER] ADI		f. ZIP CODE		10g. CITIZEN C	F WNAT COUNTRY?			
ian. transit	FUNERAL	903 Long Bar Harb				21009			States			
215-0020 attending physician. ise as the burial-transit	B	1 Never Married 2X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	It yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.) y:	B S	ACE — American Indian, leck, White, atc. pecify: hite			
21215 al or atten for use as	ETED.	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of w life. Do NOT us	rork done during me	ON ost of working	16b. KIND OF BU	SINESS/INDUSTR	Y			
AND 21 he hospital or detached for u once.	COMPL	12		Mechani	cal Eng			nufactu	ring			
YLA by the be det	8	17. FATNER'S NAME (First, Middle, Last) Frederick Vincen	t Palewick				ME (First, Middle, Maiden niana (n	Sumame)	Ctomalri			
MAK retained to 5 should notified	100	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number, City or Tow	n, State, Zip Code,				
	5	Mary E. Palewic	20h		ong Bar	Harbor I	Road, Abin		d. 21009			
9 9 -		1 & Buriel 2 Cremation 3 Hemo 4 Donation 5 Other (Specify)	wal from State	otoni oromatani ni ot	emorial	Park 4	/25/95 Ba					
death death fune fune		· mars	KM a	nert	McCo:	mas Fune: Cokesbu	ral Home ry Rd. Abi	ngdon ,	Md. 21009			
bu, sd within 24 hours after of the period		23. PART I. Enter the diseases, or c shock, pr heart failure. I IMMEDIATE CAUSE (Final disease pr condition resulting in death)		the deeth. Do nach lina.	cano		h as cerdiac Dr reap	iratory arrest,	Approximate intervel Between Onset and Death			
h certificate be execute anding physician and confidence prior to burian or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d										
그 을 들 들	AL C	PART II. Other algnificant conditions		ut not reaulting is	n the underlyin	g causa given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
) = 2 = E	FDICAL	CATCHE	disease	2			1 □ YES 2		COMPLETION OF CAUSE OF DEATH?			
law requi	N: M	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES NO			1 YES 2 NO			
IIAL I: The law cate has State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. P	LACE OF DEATH (Ch	eck only one)					
SICIAN certific h the S	PHYS	1 YES 2 NO 27. MANNER OF CEATH	1 Inpatient 2 ER/Outp	28b, TIME	OF 28c. IN.	ne 5 Residence	6 ☐ Other (Specify) 28d. DE\$CRIBE NOW I	INJURY OCCURED				
ATTENDING PHYSICIAN: The law requires ECTOR: After this certificate has been sign is after death with the State Dept. of Heal 28 is marked, or Item 23 shows.	ВУР	1 distural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 🗆	YES 2 NO						
OR ATTEND OR ATTEND DIRECTOR: / hours after of	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At nome, term, s	treet, tectory, offic		28t. LOCATION (Street City or Town, State)	and Number or Rui	al Route Number,			
절절었는	COMPL		CIAN: To the best of my knowl									
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 I		29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the beals of examination	and/or investigation	n, in my opinion, e	29c, LICENSE NUM			IED (Month, Day, Year)			
TO THE TO THE be filed iMPOR	38 C	David S.D				D32			LIJS			
	5	30. NAME AND ADDRESS OF PERSON WHO				8	0					
		31. DATE FILED (Month, Day, Year) APR 2 4 1995	2. REGISTRAN'S SIGNA	OS LA	urel	BUSH &	M					



		REGISTRAN		Cr	<u>ERIIE</u>	ICATE U	PUEATH		REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE	OF DEATH	. ,	3.	. TIME OF OEATH		
		Evelyn	Patric	cia	Phe	elan		Apr	ĭ1 13,™	"1995 '	EAN	1:50 A M		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 YEAR		7. DATE	OF BIRTH		BIRTHPL	ACE (State or Foreign		
		080-30-2122	1 🗆 M 2 🖵 F	57	YRS.	MONTHS DAYS	S HOURS MIN.		th, Day, Year) 24,193	Q N	Country)	o mle		
3 should		9a. FACILITY NAME (If not institution, give a	street and number)			96. CITY, TOW	/N OR LOCATION OF D		44,170	9c. COUNTY				
	5													
1, 2,	СТОВ	11711 College View Drive Wheaton Montgome												
permit. Pages	DIRE	10a. STATE 10b. COUNTY	4		10c, CIT	Y, TOWN OR LOC	CATION				10	Dd. INSIDE CITY		
ř. P	1 1		gomery			Silver	Spring				15	YES 2 NO		
peri	A	10e. STREET AND NUMBER					10f. ZIP CODE 10g. CITIZEN O					T.		
100	E I	11834 Charles Roa	h				20906			U.S.	٨			
215-0020 attending physician. se as the bunal-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	NT EVER IN U.S. AR	MED	13. WAS E	DECENDENT OF HISPA	NIC ORIGI	N? (Specify Yea		RACE -	- American Indian,		
Dhy bur		1 Never Merried 2 Married	FORCES? 1	1 YES 2 N WAR OR DATES	40	If yes,	specify Cuban, Maxice (ES 2 NO Specific	cify Cuban, Maxican, Puerto Rican, etc.)				Yhita, atc.		
21215-0020 al or attending physic for use as the burial	ВУ	3 Wildowed 4 Divorced	748	Ww			75 7 53 115	7.			Specify: Whit	te		
	E	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Gi	live kind of w	USUAL OCCUPA work done during	ATION most of working	160	. KIND OF BUS	INESS/INDUS				
	É	Elementary/Secondary (0-12)	College (1-4 or 5 +		. Do NOT us	ie retired.)	most or worning							
AND the hospit detached once.	₫	12		Acco	ount '	Technic	cian		Federa	1 Gove	rnme	ent		
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S NA							
1 2 2 X	ш	William Michael	Phelan				Mary (Cathe	rine R	ohan				
MARYLAND retained by the hospit 5 should be detached notified at once.	9	19a, INFORMANT'S NAME (Type/Print)		196	b. MAILING	ADDRESS (Street	et and Number or Rural				rde)			
	임	Mary Catherine Ro	che				Road Si					1 20006		
AE, nay be		20a, METHOD OF DISPOSITION		20b.PLACE A	AND DATE O	OF DISPOSITION		DAT		CATION - City	_			
MOR e 6 mg rector, p		1 Suriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	oval from State	cemetery cres	ametory or other	ther placel	Cemetery 4	1						
Page 1		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	- 1 0000	01 11	22. NAME	AND ADDRESS OF FA	ト/ エフ/	ANDITA	er spi	Ting,	Maryland		
BALTIMORE, er death. Page 6 may be the funeral director, page val.		· 111 +1	20	11			cis J. Col		Funer	al Hom	ne, J	inc.		
9 7 9		Krolenker-	Mark	burn		500 บ	Jniversity	Blv Blv	d.,W.	Sil.Sr	or.M			
# ≥ £ 0 1		23. PART I. Enter the disesses, or o	complications the	it coused the de	ath. Do n	ot enter the r	mode of dying, euc	th se cer	diec or respir	ratory srrest	t,	Approximate		
_ pa be		shock, or heart fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel Onset and Dea												
		disease or condition ovarian Cancer												
ted within completely ial, cremati		resulting in calath)	a	OR AS A CONSEC		F):								
C 68760 executed with and complet to builal, cren	2		Hepati	ic Failu	re									
OX 68: e be execute sician and control to burial traumatic	9	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										 		
BOX 68760, incate be executed with physician and comple the prior to burial, cre-	CERTIFICATION	cause. Enter UNDERLYING Partial Rowel Obstruction												
. 4 0 2 2	Ĕ	CAUSE (Disesse or Injury that Initiated events	G	(OR AS A CONSEC										
eath certificate Hygien Pr. or other	4	resulting in deeth) LAST	4											
			3.									-		
ECORDS, I pulses that the deat in signed by the atte Health and Mental ows any Injury,	A	PART II. Other significant condition	s contributing to	death but not re	esulting in	n the underly	ing ceuse given in	Part I.	24a. WAS AN /			ERE AUTOPSY FINDINGS		
OF VITAL RECOR PHYSICIAN: The law requires that this certificate has been signed by with the State Dept. of Health an riked, or Item 23 shows any	PHYSICIAN: MEDICAL								1 YES 2		co	OMPLETION OF CAUSE		
ECO quires the n signed r Health a	SE SE									L 140		DEATH?		
AL RE ne law req has been Dept. of	-	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S I NO	□ UNCERTAI	ΝП				_ YES Z _ NO		
OF VITAL R HYSICIAN: The law re his certificate has bee with the State Dept. or ked, or Item 23 sh	¥.	25. WAS CASE REFERRED TO MEDICAL				TH (Check only on								
F VITA SICIAN: The certificate h the State I t, or Item	Sic	EXAMINER? 1 Tes 2 Xno	HOSPITAL:			OTHER:								
Sicial Sertification of the	¥	27. MANNER OF DEATH	26a. DATE OF		28b. TIME	-	INJURY AT							
NG PHYS fter this eath with		1 🔼 Natural 5 🗋 Pending	(Month, De	ey, Year)	INJ	URY	WORK?	280, DE	SCRIBE HOW IN	JURY OCCUR	ED			
After After	B	2 Accident Investigation	280 DI ACE C	SF IN HIPM - At he			YES 2 NO							
DIVISION OR ATTENDING P ORRECTOR: After the hours after death v	8	3 Suicide 6 Could not be 4 Homicide determined	building,	OF INJURY — At hor , atc. (Specify)	me, farm, si	ireet, factory, on	fica	26f. LOC City	ATION (Street ar or Town, State)	nd Number or I	Purel Route	n Number,		
DIV!	E													
DIV NL OR A NL DIREC 2 hours 1 Item	COMPLETED	(Check only 1 X CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, der	eth occurre	d at the time, dr	ste and place, and due	to the ce	rse(a) and man	ner as stated.				
SPITU NERA TIP 7	S	one) 2 MEDICAL EXAMINE	R: On the basis of ar	xamination and/or is	nvestigation	n, in my opinion	, death occured at the	time, dete	and place, and	due to the co	ause(a) an	id manner as stated.		
TO THE HOSPITAL (TO THE FUNERAL (be fied within 72 h IMPORTANT: If II		296. SIGNATURE AND TITLE OF CENTIFIER	-				29c. LICENSE NUM					onth, Day, Year)		
H = 5	BE	20	0000	Ω			D2914					3, 1995		
E E Y =	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAU!	SF OF DEATH (ITE)	4 27) /Type.	Print						3, 1775		
- 1		Charles Boice, M.		15 Fernwa			03 Beth	aeda	, MD 2	20817				
				R'S SIGNATURE	J04 1	·u., 113.	O) Deci	esua	, III -	20017				
		APR 17 1995	Talia Da	veles Rand	1.11									



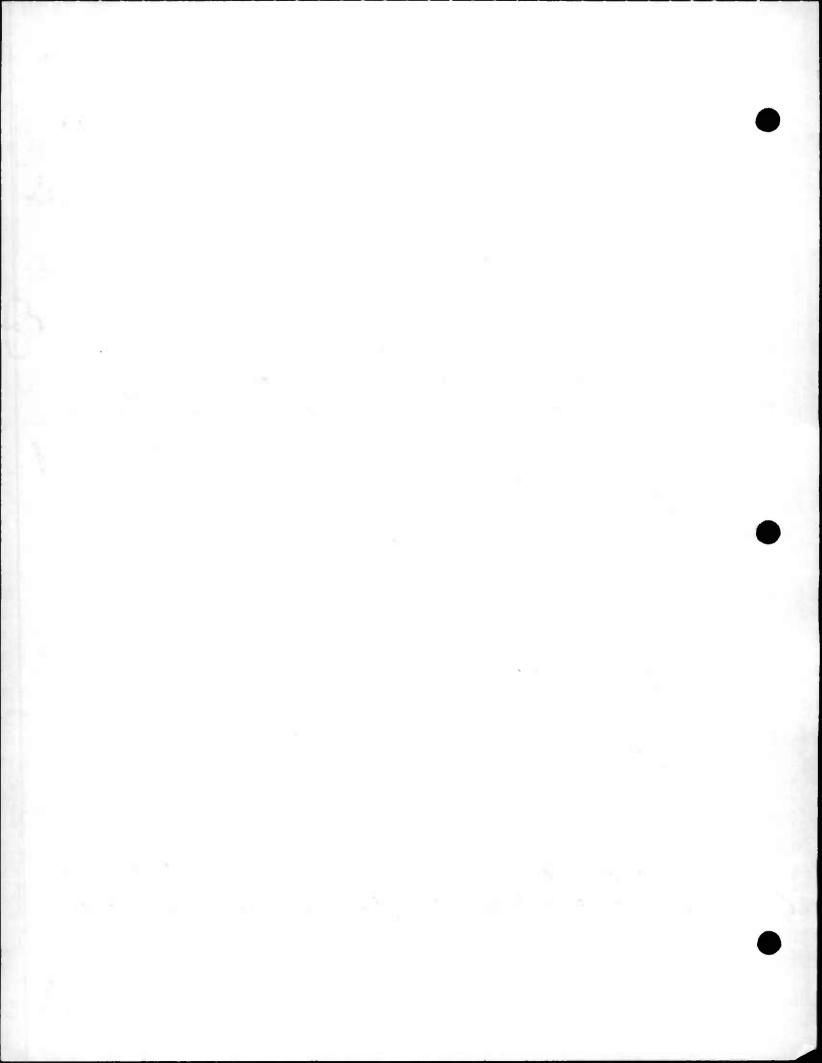
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fourth fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be nettiled at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	REGISTRAN				-NIII	ICAT	UF	DEA	I IT	RE	G. NO.				
10	1. DECEDENT'S NAME (First		MONTH							APRIL 15, 1995 3. TIME OF DEAT					
	4. SOCIAL SECURITY NUME 104-12-8034		5. SEX 1 (X) M 2 F	M 2 □ F 72 YRS.			DAYS	HOURS MIN. (Month, Din April 2			Manel	1922	Count	HPLACE (State or Foreign ry) YOTK	
<u>~</u>	9a. FACILITY NAME (if not in					OR LOCATI	ON OF DE	ATH			NTY OF E				
DIRECTOR	10922 Pleasant Acres Drive					Adelphi Prince Ge						George's			
REC	10a. STATE	10b. COUNTY				Y, TOWN						_		10d. INSIDE CITY	
												1 YES 2X NO			
RA	11372 Cherr		Pond #1	n 2			10	2070						WHAT COUNTRY? States	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	CENDENT C	F HISPAN	IIC ORIGIN? (Spi	ecify Yes		14. BACI	- American Indian	
ВУ	1 Never Married 2 3 X Widowed 4 Divo		IF YES, GIVE Y	XYES 2 N WAR OR DATES WW II	10		If yes, sp 1 🗌 YES	ecify Cuba 2 K NO	n, Maxica Specify	n, Puarto Rican,	etc.)		Spec	k, White, atc.	
TED	15. DEC (Specify onl)	EDENT'S EDU	CATION completed)	(G	ive kind of	USUAL O	CCUPATIO	ON ost of working	ng .	16b. KIND	OF BUS	INESS/INC	DUSTRY		
COMPLET	Elementary/Secondary (C	1-12)	College (1-4 or 5	•)		se retired.)				D. h I	12 -	A			
OM	17. FATHER'S NAME (First, M	liddle, Last)		ACC	ount	ant		18. MOTI	HER'S NA	PUD J		Acco	unti	ng	
BE C	John	D.	S	aunders					anet		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		resl	er	
TO B	19a. INFORMANT'S NAME (1									Route Number, Cit					
-	Sally McCas		ughter)			_			es D	rive, A			_	20783	
	20a. METHOD OF DISPOSIT 1 □ Burial 2 ★ Crematic 4 □ Donation 5 □ Other	n 3 🗆 Reme	ovel from State	20b. PLACE A cometery, crea Chesa	Matory or o	OF DISPOS other place)	ITION /Na	ame of						own, Stata	
Ιi	21. SIGNATURE OF FUNERA		pijsgt //	Linesa	peak	22.	NAME A	ND ADDRE	SS OF FA	4-18			rre,	MD	
	1	RI		MO	0027					Service			***	20242	
H	23. PART I. Enter the di	Iseeses, Dr d	complications the		0827 ath. Do i	not enter	the mo	ISU F	ing eucl	Silver	Spi	ring,	, MU	20910	
NOI	shock, or heart fellure. List only one ceuse on each line.											Onset and Deeth			
CERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or Inju- that initiated events resulting in death) LAS	ng ry	DUE TO	(OR AS A CONSEC	DUENCE O	F):									
MEDICAL	PART II. Other signification of the second o	ty	stre 6	wold	m	ul	1	der	a		WAS AN AUTOPSY PROPRIED TO COMPLITTION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO				
Ä	25. WAS CASE REFERRED TO		GBUTE TO CA	The second secon		TH /Check	Land Company of the Company	JUNC	ERTAIN	101					
Sic	1 X YES 2 NO		HOSPITAL:			OTHER	91	. se n	sidence	6 C Other (Spec	oma (i	dauat	nter	s house)	
PHYSICIA		Panding	28a. DATE OF (Month, D		28b. TIM		28c. INJ WO	URY AT		284. DESCRIBE				, noddo)	
2 Accident Investigation 3 Suicide										(Street a n. Stele)	nd Number	or Flund F	bute Aumber		
) and manner as atated.			
	20h CIANATIOE AND TITLE OF CERTIFIED									(Month, Day, Year)					
10 B	The agust by Strangues W H21230 Ment 16/95									195					
	HAGAST P	Rod	rique Zi	MP,50	0 9	Print)	bu	m C	1.0	p-8/	1.	ms	20	748	
	31. OATE FILED (Month, Day.		32. REGISTRA	R'S SIGNATURE											
	APR 1	9 1995	Juli M	Selen Res	tall									DHMH-16 Rev 1/89	

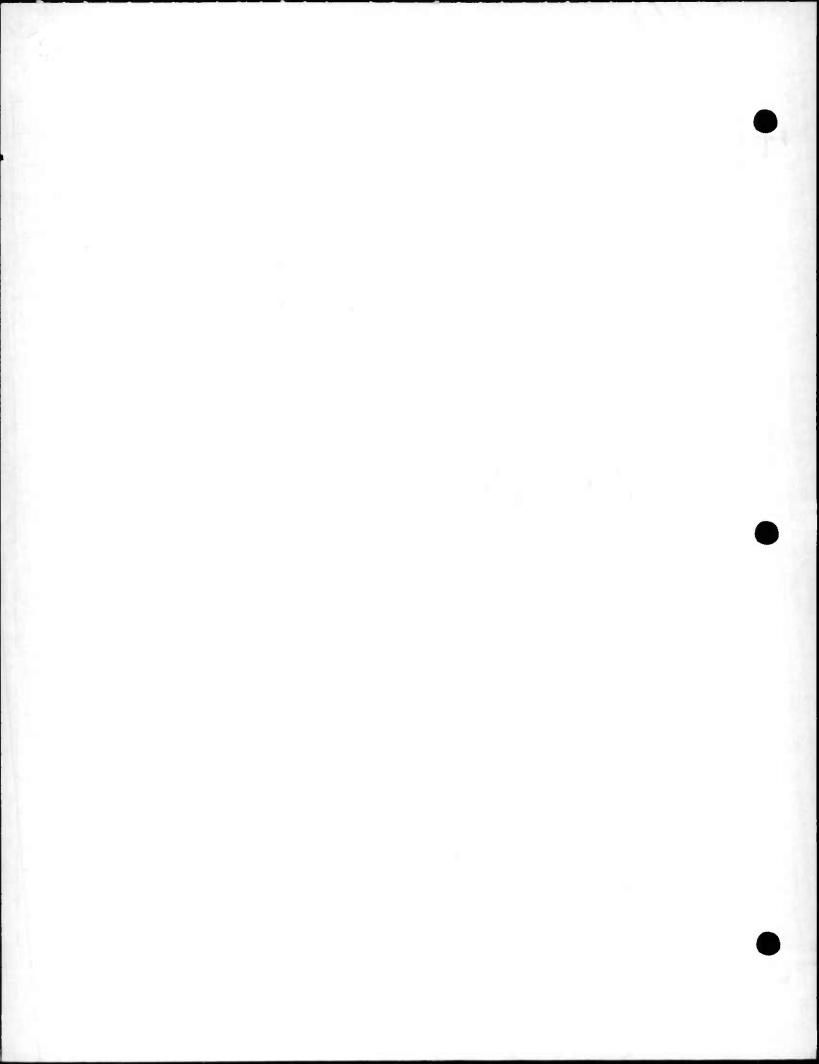


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BALTIMORE, MARTLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician,	do in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should or removal.	medical examiner must be notified at once.
CHARLES OF WITH THE CONDS, T.O. BOX 66760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	EVELYN SARAH PROMISEL 2. DAY APRIL 16, 1											995 3. TIME OF CEATH			
	4. SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH										a. BIRTHI	PLACE (State or For		
		1 🗆 M 2 😿 F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	OCT.	15,1	909	MAT	'NE		
DIRECTOR	9a. FACILITY NAME (If not institution, give stre MANOR CARE RESIDENCE OF DECEDENT	et and number)			9b. CITY,							NTGO			
EC.	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY		
	MARYLAND MON	TGOMERY		CHEVY		ASE				I so cir	TEN OF M	LIMITS?	NO		
FUNERAL	8100 CONNECTIC						20815	5			UNI		STATES		
ВУ	11. MARITAL STATUS 1 Never Married 2 📉 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EY FORCES? 1 [] IF YES, GIVE WAR	YER IN U.S. ARM YES 27 NO OR DATES	IED	11	yes, spe	ENGENT Of Cuber 2 NO	n, Maxican	IC ORIGIN? (I, Puerto Ric	Specify Yes an, etc.)	or No—	Black, Specify	— American Indian Whita, atc. V: ITE	n,	
TEC	15. DECEOENT'S EDUCA (Specify only highest grade co	TION ompleted)	(Giv	 kind of v 	USUAL OC	CUPATIO uring mos	N st of working	g	16b. K	INO OF BUS	SINESS/INC	OUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		SISTI	ERED	NUR	SE				MED	ICINE	Z		
BE CO	17. FATHER'S NAME (First, Middle, Last) LOUIS DAVIDOFF			-			18. MOTH		AE (First, Mid		Surname)				
TO B	190. INFORMANT'S NAME (Type/Print) NATHAN PROMISE	L (HUSBA	ND) 81	MAILING	AODRESS	(Street at	nd Number	or Rural R	F1406	City or Town	n, State, Zip	ASE.	MD. 208	15	
	20e_METHOD OF DISTUITION 1 (X Burlel 2 [] Distuition 3 [Remov		20b. PLACE AF	ND DATE C	OF DISPOSI	TION (Na	me of		DATE	20c. LO	CATION —	City or Tow			
	21. SIGNATURE OF FONERAL SERVICE LICE	SEE			22. N	IAME AN	D ADDRES	S OF FAC	ILITY				ELS, INC		
	Jary h	1. / Tu	e		111	70 R	CCKV	ILLE	PIKE	- ROC	KVII	JE. I			
z	23. PART I Inter the disease, or completions that caused the deeth. Do not enter the mode of dying, such ea cerdiac or respiratory arrest, Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSPOUENCE OF): Sequentially list condition D. Interval Condition D. Inte														
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
MEDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. A nem 1 2 ' 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO 24b. WERE AUTOPSY FINDING ANALABLE PRIOR TO COMPLETION OF DEATH? 1 YES 2 NO											O JUSE			
	DID TOBACCO USE CONTRI	BUTE TO CAUS	E OF DEAT	H YE	S 🗆 N	10 🗆	UNC	ERTAIN						1	
PHYSICIAN:		HOSPITAL:	28. PLACE		OTHER	:	5 (T) Res	tidence d	Other (S	inaciha)					
ву Рну	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJL (Month, Day, Ye		26b. TIME	OF :	28c. INJU WOF	JRY AT		26d. DESCR		JURY OC	CURED			
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN. building, etc.	JURY — Al hom (Specify)	e, ferm, a	treet, fecto	ry, office			261. LOCATI City or	ON (Street a Town, State)	nd Number	or Rural Ro	oute Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIA MEDICAL EXAMINER:												end manner as sta	ted.	
H	296. SIGNATURE AND TITLE OF CERTIFIER	6 par				T	290 LICE	353	35	71	29d. DAT	E SIGNED (Month, Day, Year)		
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF	F DEATH (ITEM	27) (Туре,	Print)						AP	KIL]	17, 1995		
	LEE JONATHAN MUSHE	R, M.D.,	5530 W	[SCO	NSIN	AVE	., #	1248	, CHE	VY CH	ASE,	MD	20815	Ì	
	APR 18 1995	32. REGISTRAR'S	SIGNATURE												



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DIVISION OF VITAL RECORDS, P.O. B

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retained by the hospital or attending physician.	5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 shou	notified at once.
HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed withmen hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 show within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	TANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complet be filed within 72 hours after death with the State Dect. of Health and Mental Molege prior to burial, cre-	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic even

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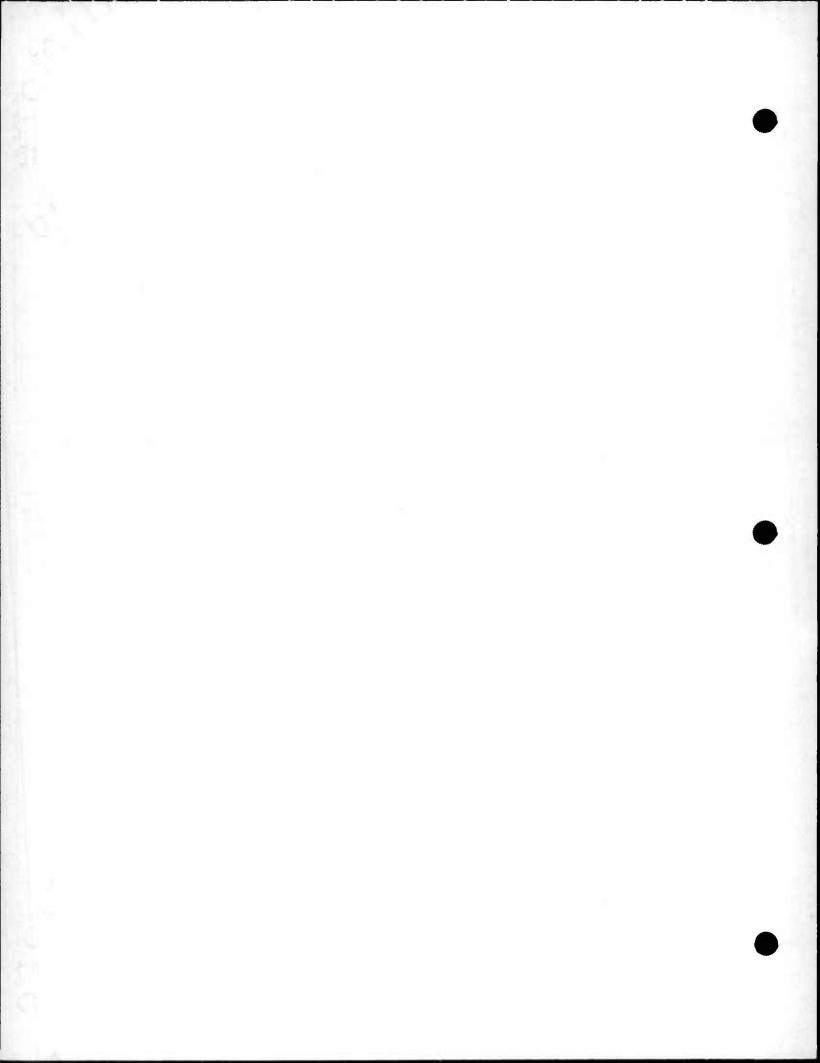
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH APRIL 13,1995 YEAR ANTOINETTE PHILIP 1:15 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
SEPT. 29, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 056-52-8931 1 🗌 M 2 💢 F 90 1904 HUNGARY 9a. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MANOR CARE POTOMAC MONTGOMERY 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY CHEVY CHASE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 8100 CONNECTICUT AVE. #1020 20815 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 ₩ Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) most of working mentary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) ARMIN SCHWARTZ BE NETTIE KLEIN 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 STEPHANIE WEISBROTH (DAUGHTER) HC-75 BOX 1723 LOCUST GROVE, VIRGINIA 22508 29a. METHOD OF DISPOSE 1 IS Burtal 2 Crembin 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State X. NEW MONTEFIORE CEMETERY 4/17 PINELAWN, NEW YORK 4 C Donation 5 C 21. SIGNATURE OF FUND 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE,MD. 20852 complications that caused tha deeth. Do not antar tha mode of dying, such as cardiec or respiratory arrest, List only one cause on each line. 23. PART I. Enter the diseases Approximate shock, or heart feitur Intervel Between **IMMEDIATE CAUSE (Final** Onset and Daath disease or condition Cell Corcinoma Transitional months reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Colitis months CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING Iron Deficiency Anemia, minths CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 ☐ Rasidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY Investigation 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide detarmined 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee atsted. ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee stated. 280. SIGNATORE AND TITLE OF CERTIFU 29g. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 40216. APRIL 13, 1995

Chase WISC, AVE. 5530 Chevy , MD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 8 1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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29b. SIGNATURE AND TITLE OF CERTIFIE

31. DATE FILEO (Month. Day.

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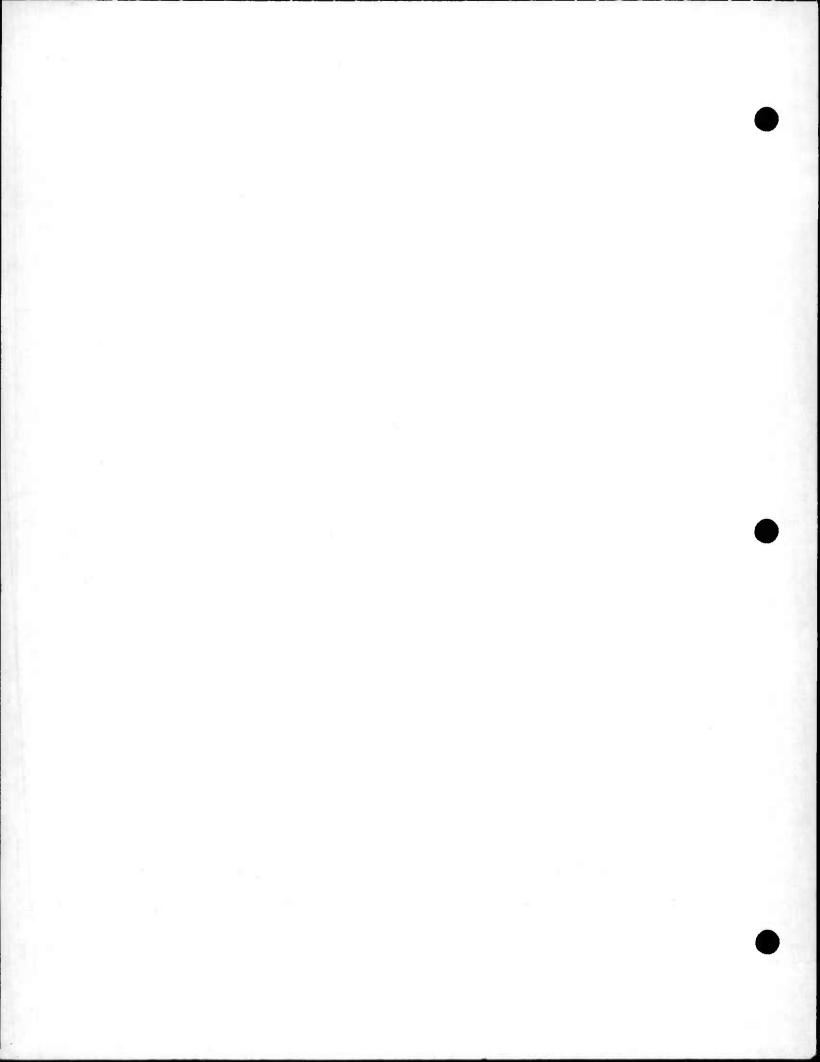
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN MONTH 3. TIME OF DEATN Igor Prissovsky April 13 1995 5:00P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. B. BIRTNPLACE (State or Foreign onth, Day, Year) 521-48-1608 1 X M 2 | F 81 Oct. 1913 Russia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Kensington 1 YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 3310 Ferndale Street 20895 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES specty White BY 3 Widowed 4 Divorced 18a. OECEDENT'S USUAL OCCUPATION 15. DECEOENT'S EDUCATION (Specify only highest grade complet COMPLETED 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5+) Chemist 12 5+ National Institutes Health 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) F Constatine Prissovsky Maria Dorofeev BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Natalie Prissovsky 3310 Ferndale St. Kensington, Md. 20895 9 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20a. METHOD OF DISPOSITION
1 □XBurial 2 □ Cremation 3 □ Ramoval from State 20c. LOCATION - City or Town, State must Holy Trinity Monastery Donation 8 Other (Specify) 4/18 Jordanville, New York examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home executed within 24 hours after death. I and completely filled in by the funeral to burial, cremation, or removal. 11800 New Hampshire Ave. Silver Spring, Md. mas medicei 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or heart feliure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition reauiting in death) event, signed by the attending physician and con Health and Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentisly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING å horyo certificate CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE thet initiated events resulting in death) LAST 0 death (in uny. PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO requires that any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO shows a t. of h 1 - YES 2 - NO PHYSICIAN: Dept. AW. s certificate has the the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item HOSPITAL: 1 - YES 2 1 HO OR ATTENDING PHYSICIAN: itient 2 - ER/Outpetlant 3 - DOA 4 Nursing Nome 5 Realdence 8 Other (Specify) 6 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. OATE OF INJURY 28c. INJURY AT with t marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Watural S Pending Investigation BY 1 YES 2 NO After 2 Accident DIRECTOR: At hours after de item 28 is r 3 Suicide 28e. PLACE OF INJURY — A1 home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide 29a. CERTIFIER
(Chack only one)

29 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as steted. FUNERAL (
within 72 h
TANT: If II HOSPITAL TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

who dander hardell

29c. LICENSE NUMBER



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

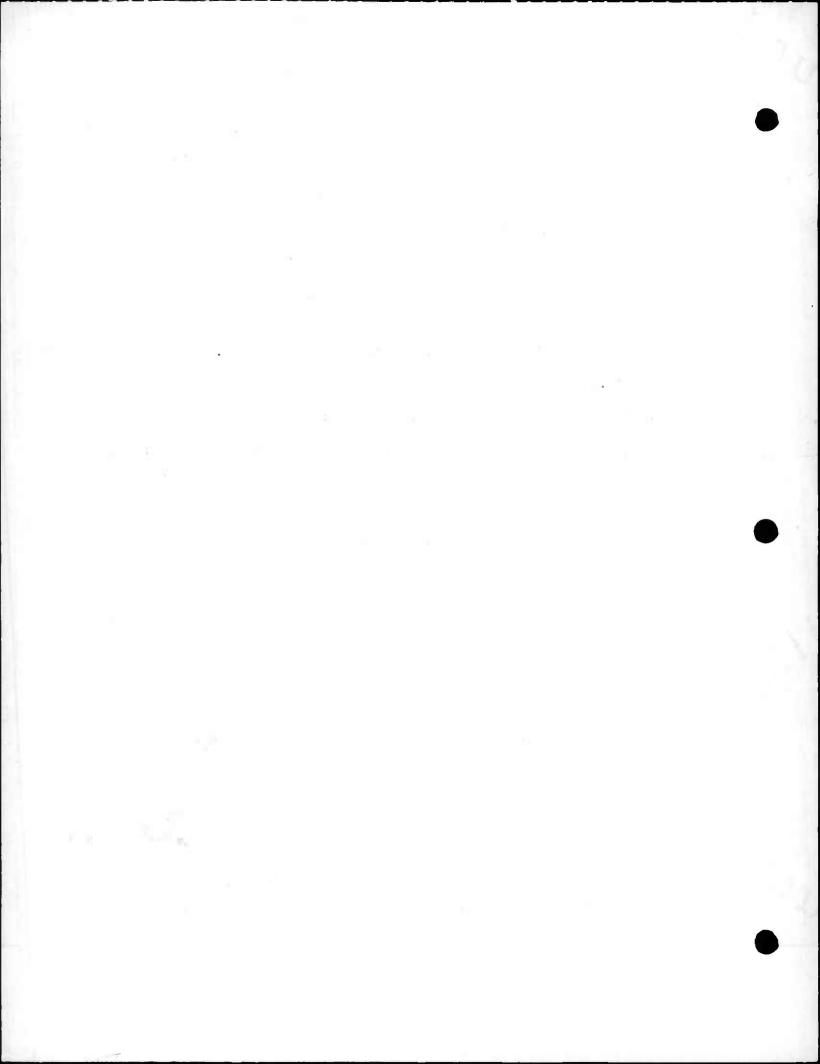
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR	STATE OF MARY		MENT OF HEALTH AND	MENTAL HYGIEN REG. NO.	_	
1. DECEDENT'S NAME (First, Middle, Li	nst)			2. DATE OF DEATH		3. TIME OF DEATH
HENRY	γ F.	PEACOCK		APR 18 1		4:55 A M
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. 1	BIRTHPLACE (State or Foreign Country)
230-22-0404		66 YRS.	MIN.	May 21, 19	28 N	orth Carolina
9a. FACILITY NAME (If not institution, g	ive street and number)	91	D. CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
NATIONAL NAVAL		ER	BETHESDA		MONT	GOMERY
10a. STATE 10b. COL		10c. CITY, T	OWN OR LOCATION			10d. INSIDE CITY
Virginia I	Fairfax	Vier	ına			LIMITS?
10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
214 Park Terrace	e Court # 79		22180		USA	
11, MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 X YE	IN U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yea	or No.— 14.	RACE — American Indian, Black, White, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	If yea, specify Cuban, Maxic 1 YES 2 X NO Speci			Specify:
15. DECEDENT'S	EDUCATION	Tata DECEDENTIA HA	1			White
(Specify only highest g	rade completed)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUS	SINESS/INDUST	RY
Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Commander		U.S.N		
17. FATHER'S NAME (First, Middle, Last)		Commander		AME (First, Middle, Maiden		
Sylvester H. H	Peacock		1000	M. Neil	Surrainey	
19a. INFORMANT'S NAME (Type/Print)	Jacock	19b. MAILING AD	DRESS (Street and Number or Rural		n. State Zin Con	(a)
Joyce D. Dysor	1		ndel Lane, Vie			,
20a. METHOD OF DISPOSITION	2	0b. PLACE AND DATE OF C	ISPOSITION (Name of	DATE 20c. LO		or Town, Stata
1 Strain 2 Cremation 3 F 4 Donation 5 Other (Specify)	lamoval from Stata	emetery cremetory or other ${ m Arlington}$ N	ational Cemete			
21. SIGNATURE OF FUNERAL SERVICE	ICENSEE		22. NAME AND ADDRESS OF F	ACILITY		
* Courst	Myer	1	MONEY & KING 171 W.Maple	Ave., Vien	na. Va	. 22180
23. PART CEnter the diseases, ahock, or heart fellu	or complications that cause on	ed the death. Do not each line.	enter the mode of dying, suc	ch ae cardiac or reapi	ratory arreet,	Approximate Interval Between
IMMEDIATE CAUSE (Finel	U					Onset and Death
disease or condition resulting in deeth)			IC ANEURYSM			
	DUE TO (OR AS	A CONSEQUENCE OF):			-	
Sequentielly list conditions,	b	A CONSEQUENCE OF):				
If any, leading to immediate cause. Enter UNDERLYING	50E 10 (011 AE	A CONSECUENCE OF).				
CAUSE (Disease or injury thet initieted eventa	C. DUE TO (OR AS	A CONSEQUENCE OF):				
resulting in deeth) LAST	4]
DATE II ON I - III I						
PART II. Other eignificent condit	tiona contributing to deeth	but not recuiting in t	he underlying ceuze given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
				¥ YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?
						1 - YES 2 1 NO
DID TOBACCO USE COI				N 🔲		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:		THER:			
1 YES 2 X NO	1 Xinpatlant 2 ER/O		Nursing Home 5 Residence			
1 Natural 5 Pending	(Month, Day, Year		F 28c, INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW IN	NJURY OCCURE	ED I
2 Accident Investigation 3 Suicida 8 Could and	28s PLACE OF IN III	RY — At home, farm, stree		28f. LOCATION (Street a	in Minibar of B	10. 1 11.
3 Suicide 8 Could not 4 Homicide detarmined	building, atc. (St	pecify)	n, radioty, offica	City or Town, State)	ing Number of N	ural riodie Number,
29a. CERTIFIER (Check only 1 X CERTIFYING PH	IYSICIAN: To the best of my kno	wiedge, death occurred a	t the time, data and place, and due	to the cause(a) and man	ner as stated.	
			s my opinion, death occured at the			use(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTI			29c. LICENSE NU			GNED (Month, Day, Year)
(92)	1	nom			18	Apr 95
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Prin	1283 NATIONA	<u>12 (MS) </u> L NAVAL ME	DICAL	CENTER
GERALD DENTO	N, LT, MC, US			OA MD 20889		OPMIEW
31. DATE FILED (Month, Day, Year)	32 REGISTRANTS SIG		DETILE	III 2000)	3000	
APR 20 199	5 Station at awales	or mandally				16



DIVISION OF VITAL BECORDS

68760 BALLIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, oremained.	atic event, the medical examinar must be notified at once.
DIVISION OF VITAL RECORDS, F.O. BOX 887.60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or remaint.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

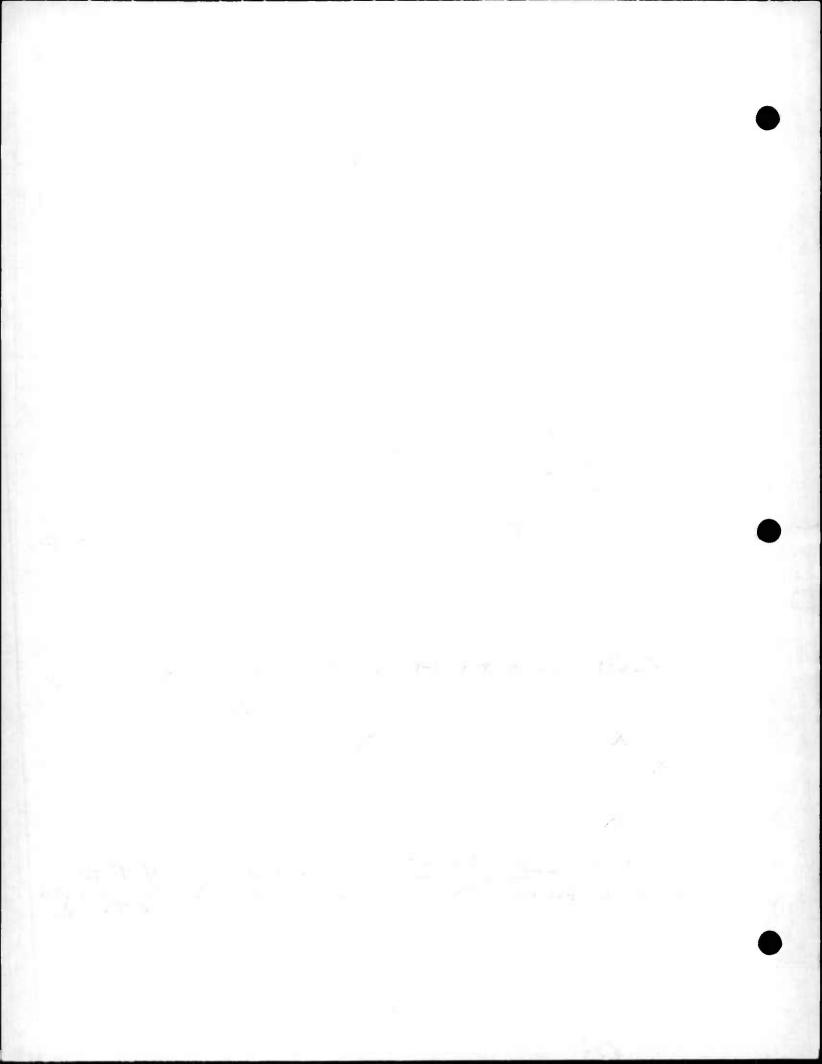
	FOR 1 - STATE	STATE OF MA					MENTAL HYGII	NE	3 3	13030	
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) Louis		Persh	IFICAT	E OF DI	EATH	2. DATE OF DEATH MONTH April 1	DAY	995	3. TIME OF DEATH 11:10 A. M	
	4. SOCIAL SECURITY NUMBER 089-03-7573	1 M 2 F	AGE (In yrs. last birth	MONTHS		UNDER 24 HRS. URS MIN.	7. DATE OF BIRTH	09	8. BIRT Coun NY	HPLACE (State or Foreign try)	
TOR	99. FACILITY NAME (If not institution, give s Bedford Court Nu RESIDENCE OF DECEDENT				v, town on Lo		EATH	%c. county of DEATH Montgomery			
DIRECTOR	10e. STATE 10e. COUNTY MONTG	omery	185	.ctv. town	Spring	ſ				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	3330 N. Leisure	World Boul	evard		10f. ZIP 209			10g. CI US		WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES 2 HO If yes, apocify Cuben, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO If yes, apocify Cuben, Maxican, Puerto Rican, etc.) 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or If yes, apocify Cuben, Maxican, Puerto Rican, etc.) 14. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or If yes, apocify Cuben, Maxican, Puerto Rican, etc.)							Yes or No-		ce.— American Indian, ck, White, etc.	
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Statistician 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relied.) Government Government										
BE COM	17. FATHER'S NAME (First, Middle, Leat) Israel Persh 18. MOTHER'S NAME (First, Middle, Melden Sumeme) Anna Norwitz										
٩	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) Mary Persh 3330 N. Leisure World Blvd. Silver Spring MD20906										
	20s. METHOD OF DISPOSITION 1 CRuriel 2 Cremetion G Removal from State 4 Donation 5 Other (Specify) King David Memorial Gardens4-20 Falls Church VA										
	21. SIGNATURE OF FUNERAL RESPVICE LIC	ENSEE	iting bav	22. E 0	NAME AND AI	Sage	oury 1 Funera	al D:	irec		
	23. PART - Enter the dicases, or o shock, or peert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Pricur	on each line.	Do not enter	the mode o	f dying, suc	h aa cardiac or re	spiretory a	errest,	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	AS A CONSEQUENC								
MEDICAL C	PART II. Other algolificent condition	e contributing to de					PERF	AN AUTOPSY ORMED?	7 241	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN: N	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUS	26. PLACE OF		only one)	NCERTAIL	1)X(1			10 123 22 40	
BY PHYS											
	3 Suicide 6 Could not be detarmined	28e. PLACE OF IN building, atc.	JURY — At home, fa (Specify)	rm, street, fact	lory, office		261. LOCATION (Stree City or Town, Sta		er or Rural	Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC PHYSI	CIAN: To the best of my								e) and manner as stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER			2	29c	D43	ABER 202	29d. DA	TE SIGNED	(Month, Day, Year)	

32. REGISTRAR'S SIGNATURE

30, NAME AND ADDRESS OF PERSON WHO COMPLETED CADDED DEATH (ITEM 27) (Type, Print) Leisve 31. DATE FILED (Month, Day, Year) APR 21 1995

OHMH-16 Rev 1/89

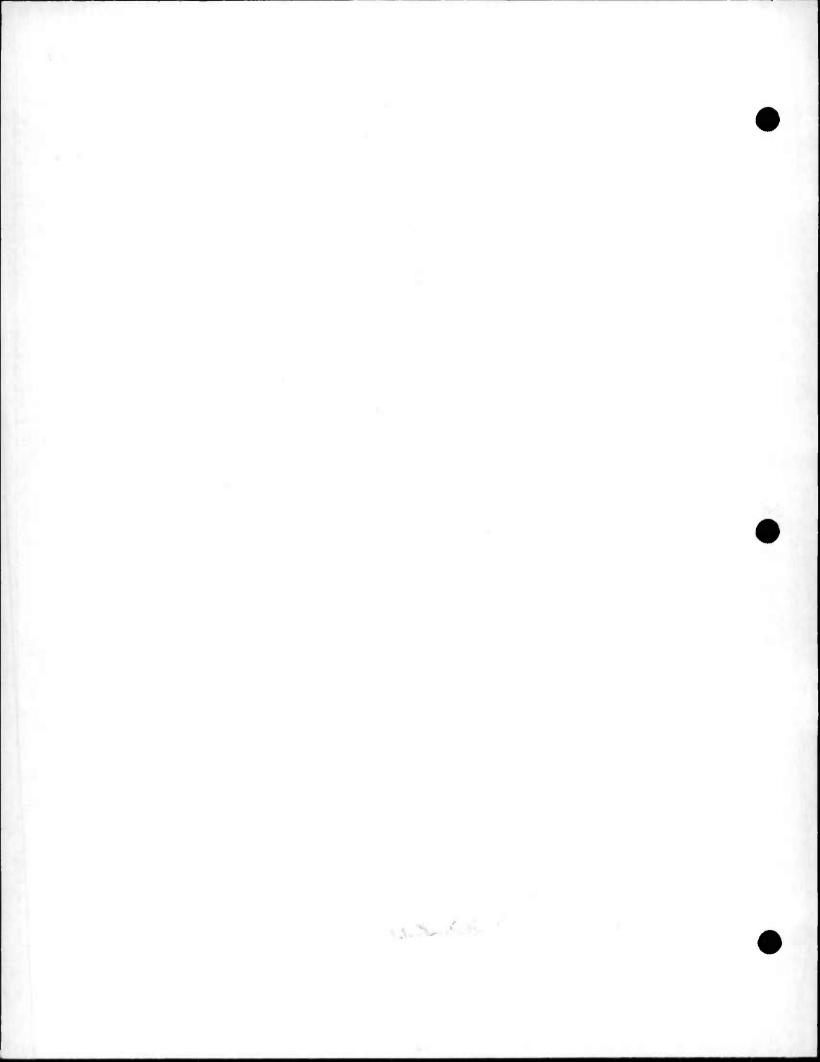
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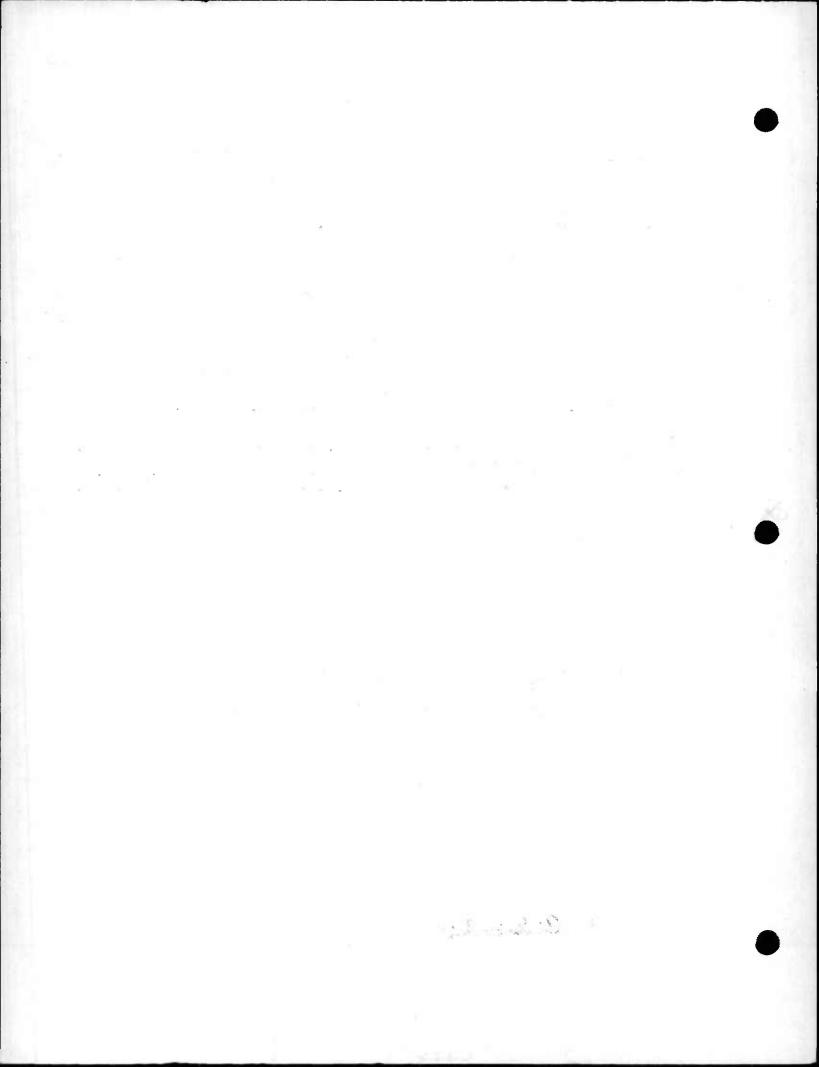
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

		REGISTRAR			ENIII	ICALE	UF	DEALL		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Li	,						2. DATE C	DA	Y	YEAR 3	. TIME OF OEATH
		Joseph Albert	PARKS, Jr.						Apri	1 23,	1995		6:00 Am
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1	1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)	1	. BIRTHPL Country)	ACE (State or Foreign
9	1	174-05-0541	1 <u>€</u> M 2 □ F	75	YRS.	MONTHS	LIAYS	HOURS WIN.	Feb.	6, 19	920		ryland
should	_	9s. FACILITY NAME (If not institution, g				9b. CITY,	TOWN	OR LOCATION OF D	EATH		9c. COUNT		
6,	СТОВ	842 S. Potomac				Ha	age:	rstown			Washington		
	I III I	RESIDENCE OF DECEDENT			10c CI	CITY, TOWN OR LOCATION							Od. INSIDE CITY
Pages	DIR	Maryland W	ashington		1000			town					LIMITS?
permit.		10e. STREET AND NUMBER	don't ing con	-		1108		of. ZIP CODE					
Sit		842 S. Potomac	Street					21740			-	USA	AI COOKTAT
-AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once.	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN			13. W	WAS DE	CENDENT OF HISPA	NIC ORIGIN?	(Specify Yes			- American Indian
215-0020 attending physic use as the burial		1 Never Married 2 Married	FORCES? 1	MAR OR DATES	NO	lf lf	Aos' st	pecify Cuben, Mexico S 2 NO Specif	en, Puerto Ri	csn, atc.)	2222		- American Indian, Whits, etc.
as the	BY	3 Widowed 4 Divorced	W.1	W.II				X			\	w]	nite
use a	밀	15. DECEDENT'S I (Specify only highest g		1	Give kind of	USUAL OC	CUPATI uring me	ON ost of working	18b, I	KIND OF BUS	INESS/INDU	STRY	
ital or	Ē	Elementary/Secondary (0-12)	College (1-4 or 5	+) "	a. Do NOT u	se retired.)				1	1.7.		
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Sil	eet n	etal	WO				blas	ting	
y the be dell		Joseph Albert						18. MOTHER'S NAME (First, Middle, Melden Surname) Harriett Louella Long					
	出	19s. INFORMANT'S NAME (Type/Print)	laiks, Si.		05 MAIL 1916		(0)	and Number or Rural			0		
MAR retained 1 5 should notified	입	Jeffery L. Par	ks					er Road,					42
e ge be		20s. METHOD OF DISPOSITION		20h PLACE		OF DISPOSIT			DATE		CATION - CI		
EALLIMORE, er death. Page 6 may be the funeral director, page val.		1 X Buriet 2 Cremation 3 F 4 Donation 5 Other (Specify)	Ismovat from State			ven C			-26-9				Maryland
ALLIMOR leath. Page 6 m funeral director, xaminer must		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	- P MC.	Je Ha		_	ND ADDRESS OF FA		J 114,	gerse)wir,	Maryland
ALIIN death. Pag funeral di		> SCAN		nema				IICH FUNE					
after d after d yy the moval.		DO DADE I STATE OF		UVIVI	m,			E.Wilson					d. 21740
S = 5	1	23. PART i. Enter the diseases, shock, or heart feilu	or complications that re. List pnly pne ceu	it ceused the duse on each lin	eeth. DD	not enter t	the mo	ode of dying, suc	ch es cerdi	ac or reepi	ratory srres	it,	Approximate interval Between
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ted within 24 completely fille ial, cremation, event, the		resulting in desth)											immediate
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OX 68 e be elecuted by the best of the control of	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b	(OR AS A CONSE	OUENCE O	F):							
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viries that signed by Health and										1 TYES 2	M NO		F DEATH?
law requisited the second as been second begging of the second se	Σ	DID TOBACCO USE COI	ATDIRLITE TO CA	LISE OF DE	ATLI VI	EC [] N	10 F	T UNICEDTAIL				1	YES 2 NO
Sep as L	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				TH (Check or							
N: The Ficate State	SIC	EXAMINER?	HOSPITAL:			OTHER:	:		4 Fl 44				
HYSICIA HYSICIA Nis certii vith the	H	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b. TIM	E OF	28c. IN.	ne 5X Mesidencs		RIBE HOW IN	JURY OCCU	RED	
arke with	ВУ Р	1 Natural 5 Pending	04/2	3/95		OAM		ORK? YES 2 X NO					hot wound
TENDING OR: After offer death	28s. PLACE OF INJURY — At homs, term, atreet, tectory, office 28s. LOCATION (Street and Number or Rural Rou												
ATTEN CTOR										St.	Hagerstown		
													-agerocown
로 내 오 노	A Homicide determined Residence 4 Homicide Residence 84.2 S. Potomac S											nd manner as stated.	
FUN WITH													
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≒ ₹ 2 ₹	유	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAU	SE OF DEATH (ITI	M 27) (Type	. Print	_	D0106	2		4/	24/	70
		Edward W. Ditto	. TTT. M.F	217	W	Jachi	ngt	on St.	Наод	rstown	. MD	21	740
		31. DATE FILED (MONTH), Day, Year)	32. RBSISTRA	AR'S SIGNATURE	5	1	-60		age	LUWI	, 1110.	2.1	, 10
		APR 2.4 !!	المالة المالة	1111	anhall	į							



	_	REGISTRAR		CERTIF	ICALE	OF DEATH	REG. NO							
		1. DECEDENT'S NAME (First, Middle, Lest) $Adna \qquad \qquad R$	ichard		PIERC	E	2. DATE OF DEATH MONTH D	AY YEAF 17 1995	3. TIME OF DEATH 8:24 a.m.					
-		4. SOCIAL SECURITY NUMBER 220-18-1459 90. FACILITY NAME (# not institution, give	0	(In yrs. last birthday) 2 YRS.	IF UNDER 1 YE		7. DATE OF BIRTH	913	THPLACE (State or Foreign Intry)					
2, 3 shoule	e B	Avalon Manor Home	street and number)		96. COUNTY OF DEATH Washington Co., Hagerstown Washington									
Pages 1, 2	DIRECTOR	100. STATE 10b. COUNT MD. Was	hington		y, town on Lo				10d. INSIDE CITY LIMITS?					
ssit permit.	FUNERAL (100. STREET AND NUMBER 11544 Big P				101. ZIP CODE 21711		10g. CITIZEN O	1 TIZEN OF WHAT COUNTRY?					
41215-0020 al or attending physician. for use as the burial-transit permit. Pages 1, 2, 3 should	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 RO	If yes	DECENDENT OF HISPA , specify Cuben, Mexico YES 25 NO Specifi	NIC ORIGIN? (Specify Year, Puerto Ricen, atc.)	ee or No- 14. RACE - American Indian, Black, White, etc. Specify: White						
AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran	ETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	ICATION o completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u.	work done during se retired.)	ATION of most of working		JSINESS/INDUSTRY						
8 8 8 E	COMPL	17. FATHER'S NAME (First, Middle, Last) UNKNOWN		444		18. MOTHER'S NA	Security Company MER'S NAME (First, Middle, Meldon Surneme) dia Pierce							
retained 5 should	TO BE	190. INFORMANT'S NAME (Type/Print) Mildred B. P	ierce	196. MAILING 1 154	ADDRESS (Sm 4 Big	eet end Number or Rural Pool Rd	Route Number, City or Tow	Big Pool, MD. 21711						
ALTIMORE, death. Page 6 may be fureral director, page		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ren 4 Donetion 5 Other (Specify)	noval from State	D. PLACE AND DATE	of disposition	Name of . 04-19-	DATE 20c. LO	ig Pool	Town, State					
0 = 0		22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD. 2172 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximete												
within 24 hours pletely filled in 1 cremation, or re		Interval Between IMMEDIATE CAUSE (Final disease or condition reculting in death) Due to (or as a consequence of):												
ficate be execute physician and cone prior to buriane traumatic	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
# 5 # 6		PART II. Other significent condition	d	out not resulting	in the underl	ving ceuse given in	Part I. 24a. WAS AN	AUTOPSY	4b. WERE AUTOPSY FINDINGS					
signed by Health ar	MEDICAL	Antero release	as Condins	roul !	Minen	_	PERFOI	RMED?	AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO					
2 90 5	SICIAN: I	25. WAS CASE REFERRED TO MEDICAL	cupilin in	den chi		. PLACE OF DEATH (CH								
SICIAN: The I certificate ha h the State Do	Sic	EXAMINER?	HOSPITAL: 1 Inputient 2 ER/Out	patient 3 DOA	OTHER:	Home 5 - Reeldence								
HYSIC this cer with th	ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c.	INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW	NJURY OCCURED						
DIRECTOR: After hours after death	ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	f — At home, farm, cify)	atreet, factory, o	office	28t. LOCATION (Street City or Town, Stete)		al Route Number,					
DIV DSPITAL DR A JNERAL DIREC Thin 72 hours INT: If Item	COMPL		CIAN: To the best of my know						e(e) and menner es stated.					
TO THE HOSPITAL (TO THE FUNERAL D BE FIED WITHIN 72 IN IMPORTANT: IF IN	TO BE		testi mo			29c. LICENSE NUI		29d. DATE SIGN	ED (Month, Day, Year)					
		30. NAME AND ADDRESS OF PERSON WI	1-u, mo 3	34 M		T HAGE	RITOWN	~ 2	1740					
		APR'I' 8 1995 Ju	32. REGISTRADE SIGN	ATURE										



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF GEATH 1995 Charles Raymond Palmer 12:28 April 13 aM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Dev. Year) 8. BIRTHPLACE (State or Foreign HOURS 1 K M 2 | F 215-24-0431 YRS 66 December 31 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 104 Beech Street North East Cecil. RESIDENCE OF DECEDENT 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil North East 1 X YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4 Church Point Road 21901 United States the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 X YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married B 1 ☐ YES 2 NO Specify: Specify: White 3 Widowed 4 Divorced USMC Korea 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION

The blood of work done during most of working COMPLETED 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Do NOT Recreational Boat Elementary/Secondary (0-12) College (1-4 or 6+) Recreational 6 Boat Painter Storage & Repair Firm 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) hours after death. Page 6 may be retained by I 76 Charles Daniel Palmer BE Bertha Heverin notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles R. Palmer, II 104 Beech Street, North East, MD 21901 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must 1 🔀 Burlat 2 □ Cremation 3 □ Ramoval from State 4 Donation 6 Other (Specify) North East Methodist Cem. 4/15 North East, Maryland 21. SIGNATURE GE-FUNERAL SERVICE LICHNSEE examiner 22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East MD 21901 filled in by the fullon, or removal. what medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death cremation, the disesse or condition ____ and completely fit burial, cremation MILHASTATIC event, DIVISION OF VITAL RECORDS, P.O. BOX 68769 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. 10 QUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediata signed by the attending physician Health and Mental Hygiene prior the requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST 6 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? апу 1 TYES 2 NO OF DEATH? Shows 1 TES 2 NO t. of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. W 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF GEATH (Check only one) The certificate I Hem HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED this c marked. 1 Natural 5 Pending 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcide DIRECTOR: A hours after d 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 ETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL E FUNERAL D S within 72 h (Check only one) TO THE HOSPITA
TO THE FUNEBA
be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CI 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 32394 4-13.95 9 30 NAME AND ADD MPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

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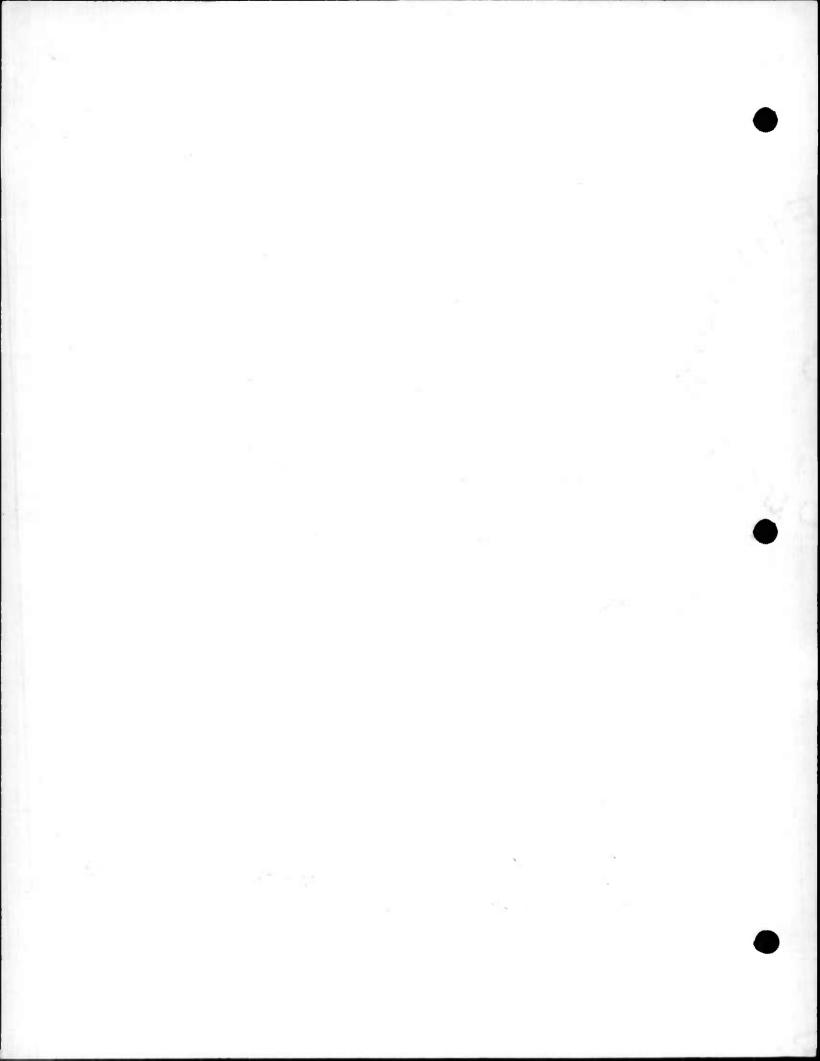
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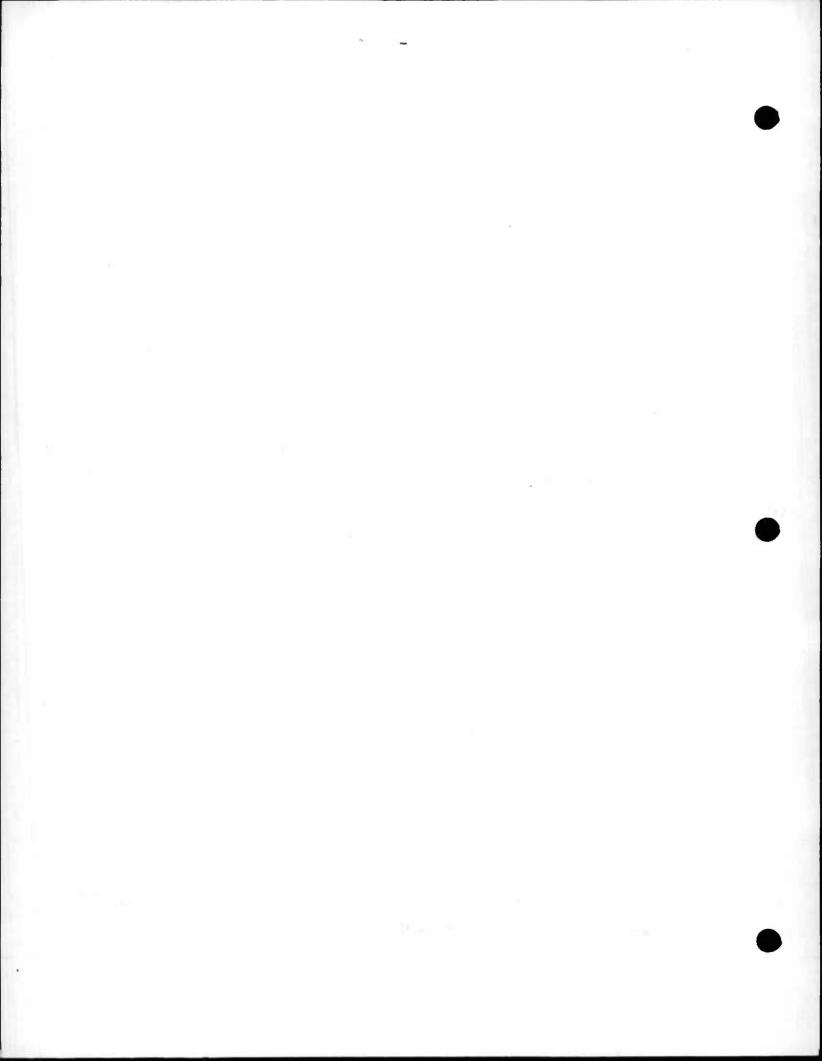
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DHMH-16 Rev 1/89



	IU.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. If yours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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STATES OF VINE RECORDS, F.O. BOA 88780	HE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu ed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	
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		FOR 1 - STATE	STATE OF M					ID MEN	TAL HYGIEN	E	J 1	0040
		REGISTRAR		Cl	ERTIF	ICATE OF	DEATH		REG. NO.			
1.		1. DECEDENT'S NAME (First, Middle, Las		61	(7		2. D	ONTH . D		YEAR	TIME OF DEATH 40
8		4. SOCIAL SECURITY NUMBER		thriE		Lucer	_		Auril 19 199			22 p M
			1 M 2 F	6. AGE (in yrs. let		MONTHS DAYS	HOURS M	RS. 7. D.	ATE OF BIRTH North, Day, Year)	8	Country)	ICE (State or Foreign
Pin		255-03-0929	- 1	84	YRS.				ne 30,1		labar	
3 should	oc.	9a. FACILITY NAME (If not institution, giv				96. CITY, TOWN				9c. COUNT	Y OF DEAT	Н
4	10	Brevin Nursing	Home			Havre	de Grad	ce		Harf	ord	
ges 1	RECTOR	10a. STATE 10b. COUR	(TY		10c. CIT	Y, TOWN OR LOCA	TION				100	I. INSIDE CITY
UZO physician. burial-transit permit. Pages 1, 2,	5	Maryland	Harford			Aberdeer	1				12	LIMITS? YES 2 NO
E Se	A	10e. STREET AND NUMBER				10	H. ZIP CODE			10g. CITIZE		COUNTRY?
nsit	FUNERAL	35 Hillman Co	urt				21001			U.S	Δ	
ND ZIZIS-0020 hospital or attending physician. ached for use as the burial-tran	15	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	MED	13. WAS DE	CENDENT OF N	SPANIC OF	IIGIN? (Specify Yes			American Indian, hita, etc.
g physic e burial	BY F	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA	R OR DATES	NO		pecify Cuban, M S 2 🙀 NO S		rto Rican, atc.)		Black, W Specify:	hita, etc.
as the		3 Widowed 4 Divorced									Whit	ce
atte nase	ETED	15. DECEDENT'S Et (Specify only highest gra	DUCATION ide completed)	/G	live kind of	Work done during m	ON ost of working		16b. KIND OF BUS	SINESS/INDUS	TRY	
d for	Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	7.5	Do NOT u							
he hospit detached once.	COMPL	17. FATNER'S NAME (First, Middle, Last)	0	Sew	ng	Machine	_		Manufac		q	
of the pe deti			Cathada						rst, Middle, Maiden	,		
	8	William George	Guurre						ll Speak			
s should notified	임	Mr. Jerry Queen		19		ADDRESS (Street						
S S D D		20a. METNOD OF DISPOSITION		10000		illman (2100	
6 may ector, pag		1 Suriel 2 Cremetion 3 Ra 4 Donation 8 Dother (Specify)	moval from State	cemetery, cre	matery or o	of disposition (Nather place) Memoria	ame of			CATION — CIT		
		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	HILLY	<u>lew</u>		L Park		/25 Alex	kander	City	, Ala.
death. Page 6 m funeral director, i.		M. 0	10- 2						uneral E	lome.	P.A.	
0 - 0		Dowy K.		vann					uneral H and 210			
5.5 6		23. PART I. Enter the diseases, o shock, or beert fellure	r complications that	caused the de	ath. Do	not enter the me	oda of dying,	such ss	cardiec or reepi	ratory srres	t,	Approximata
y filled i		IMMEDIATE CAUSE (Final					T		0 -			Interval Between Onset and Daath
within 24 in apletely fille cremation,		disease or condition resulting in death)	\$	ante n	40	ur dra	1 +1	191	clim			lhr
			DUE TO (C	OR AS A CONSE	DUENCE O	F):						
executed and como burial.	8	Sequentially list conditions,	ь.									
ite be execut ysician and o prior to buri	CATION	if sny, leading to immediate cause. Enter UNDERLYING	DOE 10 (C	OR AS A CONSEC	DUENCE O	F):						
ine play	윤	CAUSE (Disease or Injury	C. DUE TO (C	OR AS A CONSEC	DUENCE O	E)·						
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the death the atten I Mental H	B		d									
of the		PART II. Other algnificent condition	ona contributing to d	eeth but not r	eaulting	in the underlyin	g cause giver	n In Part i	24a, WAS AN PERFOR			RE AUTOPSY FINDINGS ILABLE PRIOR TO
w requires that the been signed by to the alth and shows any in	MEDIC/								1 TYES 2	Tig-	COL	MPLETION OF CAUSE DEATH?
aguire of He	M											YES 2 NO
has be Dept.	ÿ	DID TOBACCO USE CON	TRIBUTE TO CAU	ISE OF DEA	TH YE	S INO	UNCERT	AIN 🗆				
VSICIAN: The law riscertificate has been the the State Dept. of them 23 sl	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check only one) OTHER:						
CIAN:	YS!	1 TYES 2 NO	1 - Inpatiant 2 DK		□ DOA	4 Nursing Non	ne 5 🗆 Rasider	nce 8 🗆 C	Other (Specify)			
ATTENDING PHYSICIAN: The ECTOR: After this certificate his safter death with the State D 28 is marked, or item	РНУ	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF IN (Month, Day,	NJURY ; Year)	28b, TIM	JURY WO	JURY AT ORK?	1.11-	DESCRIBE HOW IF	NJURY OCCUP	RED	
DING PHYS After this of death with	βÁ	2 Accident Investigation					YES 2 NO					
TTEND TOR: A after d	유	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF building, at	INJURY Al ho Ic. (Specify)	me, farm,	atreet, factory, offic	ia .	28f. I	LOCATION (Street a City or Town, State)	nd Number or	Rural Route	Number,
DR ATTENDING DIRECTOR: Atter hours after death item 28 is ma	<u> </u>											
보 기 가 보	MP.	(Check only	SICIAN: To the best of m									
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	COMPLETED	2 MEDICAL EXAMI	NER: On the basis of exa	mination and/or i	nveatigatio	on, in my opinion, o	leath occured at	t the time, o	data and placa, and	d due to the c	ause(s) and	manner ea stated.
H H H H P P P P P P P P P P P P P P P P	BE (296. SIGNATURE AND TITLE OF CERTIFI	ER AAS				29c. LICENSE			29d. DATE S	IGNEO (Moi	nth, Day, Year)
TO THE HOSPIT TO THE FUNERA be filed within 7	10	wanam	,vu)				h 35	-609		▶ y	2010	U
		30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAUSE	OF DEATH (ITE			10.	0	(00			- d
		NAME OF THE PARTY	vinami Mi	103 4	tond	ultur St	Mar	te Di	e gran	i mi	1210	1.8
		APR 21 1995	REGISTRAN	SIGNATURE	11							
	- 3	MFR & 1 1333	June 10 HOL	AND A COLOR	0-T							



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

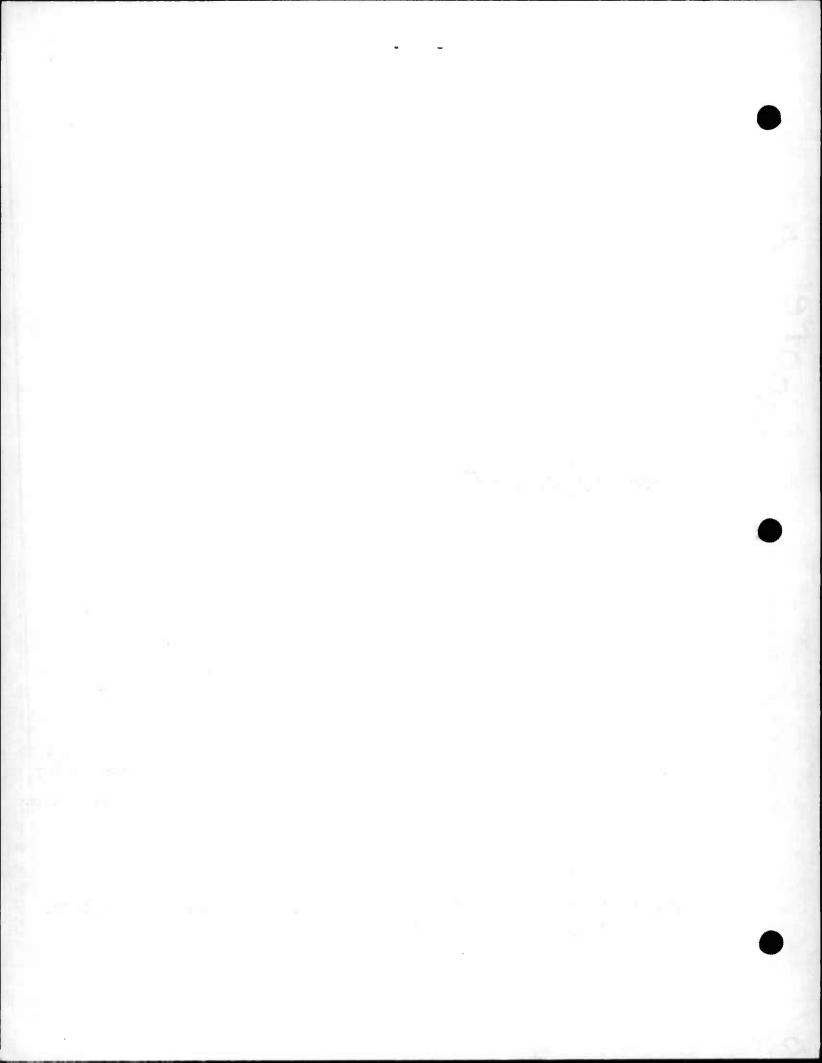
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF I	MARYLA		EPARTA RTIFIC					MENT	AL HYGIEN			
1. DECEDENT'S NAME (First	, Middle, Lest)										E OF OEATH			3. TIME OF DEATH
Matthew		Se	an		P	il.	037			MON	m w		YEAR	0437 M
4. SOCIAL SECURITY NUME		5. SEX		yrs. last b		UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE					IPLACE (State or Foreign			
216-94-3179		1 M 2 - F	22		YRS. MO	HTHS	DAYS	HOURS	MIN.		nth, Day, Year)	972	Count M Δ I	RYLAND
90. FACILITY NAME (If not in	stitution, give si	treet end number)			91	a. CITY	r, TOWN	OR LOCATI	ON OF D		17,		INTY OF E	
Garrett Co	Ounty	Memori	al H	losp	ital		0ak	land					irre	
10a. STATE	10b. COUNTY	,			10c. CITY, T	OWN (OR LOCA	TION						10d. INSIDE CITY
MARYLAND	GAR	RETT			SWA	NT	ON							LIMITS?
10e. STREET AND NUMBER						_	10	. ZIP COD	E			10a, CIT	IZEN OF V	WHAT COUNTRY?
222 TURKEY	NECK R							1561				US		
11. MARITAL STATUS 1 XX Never Married 2	Married	12. WAS DECEDEN FORCES? 1				13.	WAS DEC	ENDENT C	OF HISPAI	NIC ORIG	IN? (Specify Yes o Ricen, atc.)	or No-		E — American Indian, k, White, etc.
3 Widowed 4 Oivo		IF YES, GIVE V						2 📉 NO			o moon, arc.,		Spec	
15. OEC (Specify only	EDENT'S EDUC y highest grade	CATION Completed		16a. DECE	DENT'S USI	UAL O	CCUPATIO	ON		16	Bb. KIND OF BUS	SINESS/IN	DUSTRY	
Elementary/Secondery (0		College (1-4 or 5	+)		kind of work o NOT use re ENTIC						ELECTR	TCAL		
17. FATHER'S NAME (First, M	iririla I cott													
REESE LEWI		EY									, Middle, Meiden		DDEC	TTT 1
19e. INFORMANT'S NAME (7							_		TTY		U ELLEN	-	RDES	TY
BETTY RILEY	урв/-ппс)										mber, City or Town			61
BETTY RILEY 222 TURKEY NECK ROAD SWANTON, MD 21561 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of a control of the														
1 M Buriel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) WHITE CHURCH CEMETERY 4/21 OAKLAND, MARYLAND														
21. SIGNATURE OF FUNERA	JU d	Dui	+ M	10016	7			FUN					OX 2	43 D 21550
23. PART I. Enter the di	seases, or c	omplications the	t caused t	the daeti	h. Do not	antar	the mo	de pf dvi	ng. suc	h en ce	rdiec or resoi	ratory ar	rest.	Approximate
shock, or he IMMEDIATE CAUSE (Findisesse or condition resulting in death)	asit fallure. I	List only one cau	on asc	ch lina.									,	Interval Between Onset and Daath
Tooling in bounty		DUE TO	(OR AS A C									-		+
Sequantially list condition if any, leading to immecause. Enter UNDERLY!	dieta NG	DUE TO	(OR AS A C	CONSEQUE	ENCE OF):									
CAUSE (Disease or inju that initiated events resulting in death) LAS	*	DUE TO	(OR AS A C	CONSEQUE	ENCE OF):									
PART II. Other algnifice	nt conditions	contributing to	death but	t not res	uiting in ti	he un	darlying	ceuss o	iven in	Part I.	24a. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS
											PERFOR	MED?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
										_	1 XYES 2	□ NO		DF DEATH?
DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF	DEATH	1 YES		NO [l UNC	ERTAII	ч П				1)X YES 2 - NO
25. WAS CASE REFERRED TO	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
EXAMINER?		HOSPITAL:	XER/Output	tient 3 🗆		HEF		6 D Da	aldonas	e 🗆 ou	er (Specify)			
27. MANNER OF DEATH		28e. DATE OF	INJURY		8b. TIME OF		26c. INJ		sidence		SCRIBE HOW IN	Lilley oc	CURED	COLLICION
	Pending	(Month, D	ay, Year)		INJURY	M	WO	RK7	1 NO	beni	02 114	7) 1/3	# IV	-D GRIEGT
2 Cutote	nveatigation	28e. PLACE O	F INJURY -	- At home	form stree	t fact		1111	11.0	NI-CO	CATION (See	0 42	11/	
	Could not be setermined	building,	etc. (Specify	SIRE		.,	ory, orne	•		JASI	CATION (Street e y or Yown, Stete) Oran 2 11			AKLAND MP
29e. CERTIFIER	IEVING BUVELO	MAN. To de						-			7 110		-	אמן אויייארייין
(Check only one) 2X MEDI	CAL EXAMINER	CIAN: To the best of a: On the bests of ea	my knowled	dge, death and/or inve	occurred at	the ti	me, date	end place, eath occur	end due	to the ca	euse(e) end men	ner ee stat	led.) end menner ee stated.
290. SIGNATURE AND TITLE		1 0/1		7				_			prece, enc			
MAIS	OF CENTIFIER	Holl.	7	#			- 1	29c. LICE						(Month, Day, Year)
		aver		//_	N			0	.C.	M.E		Ap	ril	18 1995

Street, Baltimore,

REGISTRAR'S SIGNAL

Maryland

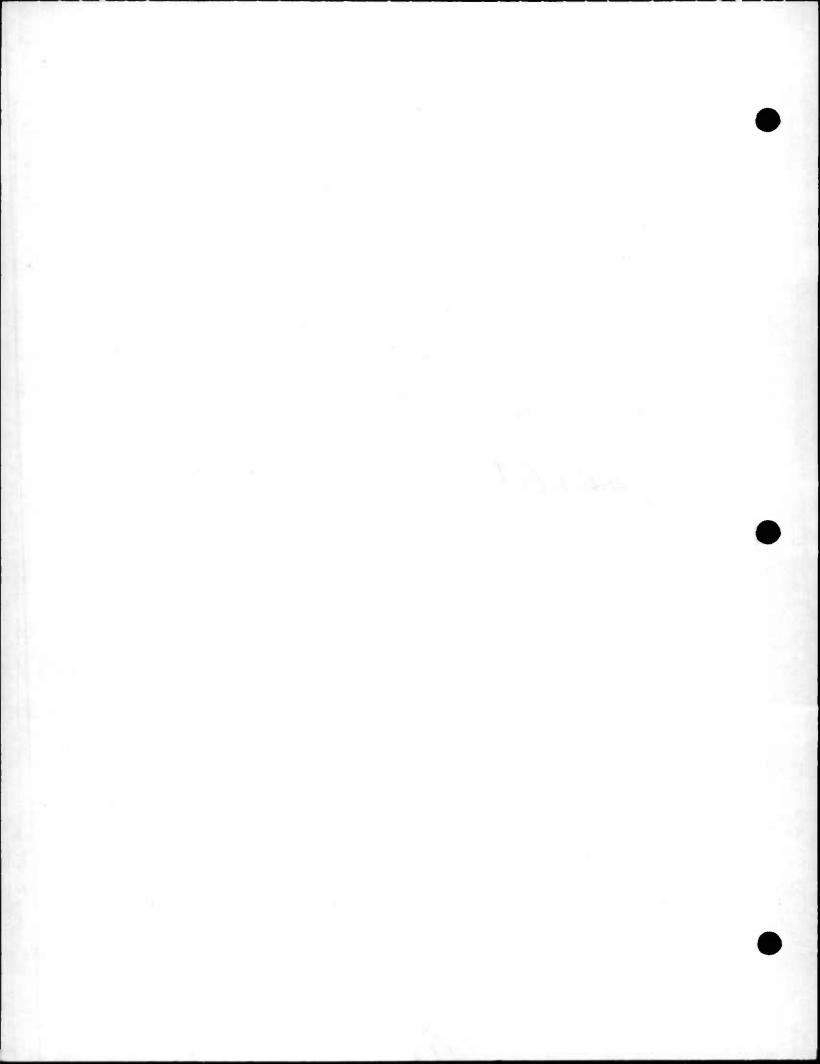


DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	MPORTANT: If Item 28 is marke

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
	HERMINIO	RIVERA, SI				APRII	APRIL 12, 1995			7:10 A M				
oc	4. SOCIAL SECURITY NUMBER		5. SEX 8. AGE (In yrs. last			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
	126-22-4781		¹₩ ² □ ^F 91		YRS.	UATS DATS	ACONS MIN.	April	April 25, 19		903 Puerto Rico			
	9s. FACILITY NAME (If not institution, give street and number)										9c. COUNTY OF DEATH			
힏	7201 Flower Avenue					Takoma Park Pr				Prin	rince George's			
DIRECTOR	10e. STATE 10b. COUNTY 1											0d. INSIDE CITY		
	Maryland Prince George's					Takoma Park			1			LIMITS?		
\%	10e. STREET AND NUMBER					10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	7201 Flower Avenue					20912 United					ted S	tates		
급	1 Never Married 2 K Married FORCES? 1 YES 2 XNO					If yes, specify Cuban, Maxican, Pu				arto Ricen, etc.) Black, White,				
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					1 X YES 2 NO Specify: Puerto Rican Specify: White					White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give					DENT'S USUAL OCCUPATION lind of work done during most of working 16b. KIND OF BUSINES:								
9	Elementary/Secondary (0	fe. Do NOT use reti	Do NOT use retired.)											
M	12 Tai					.lor			Clothing / Alterations					
ပိ									ME (First, Middle, Maiden Surname)					
BE	Policarpio Rosa Rivera Ana Maria Ruiz 196. INFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											NUIZ		
2	Benjamin Rivera, Sr. (Son) 813 Forston Street, Takoma Park, MD 20912													
	20e. METHOD OF DISPOSITI		val from State	20b. PLACE	E AND DATE OF DE	SPOSITION (No		OATE	_	CATION — C	ity or Town	, Stats		
	4 Donation 5 Other	of Heav	eaven Cemetery 4-17 Si]				ver Spring, MD							
	21. SIGNATURE OF UNERAL SERVICE LICENSEE					22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A.								
	M00827					933 Gist Ave, Silver Spring, MD 20910								
	23. ART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate													
	IMMEDIATE CAUSE (Fine) Onset and Death													
	disease or condition resulting in death) a. Smoke inhalation and thermal injuries													
	DUE TO (OR AS A CONSEQUENCE OF):													
ON	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):													
AT	If any, leading to immed cause. Enter UNDERLY!	i i												
H.	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	resulting In deeth) LAST													
CC	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY FINDINGS													
MEDICAL									PERFORMED?			AMILABLE PRIOR TO COMPLETION OF CAUSE		
											OF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y					S NO UNCERTAIN			(Partial)		1 '	YES 2 NO		
SI	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) FYAMINERS?													
BY PHYSICIAN:	1X YES 2 NO 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 X Residence 8 □ Other (Specify)													
F	27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Jay, 19ar) 1 Natural 5 Pending 1 2 0 5					26b. TIME OF 28c. INJURY AT WORK?			28d. DESCRIBE HOW INJURY OCCURED					
	2 K Accident Investigation 4-12-33 2.1					irm, street, factory, office 26			Victim of house fire					
E	building, atc. (Specify)								281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7.201 Florion Ave. Takoma Portk MD					
9	Restuence /201 Flower Ave, lakoma Park, M											ulia Park, MD		
COMPLETED	CERTIFUNG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and dus to the cause(s) and manner as attated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dus to the cause(s) and manner as stated.													
\mathcal{L}	_ MCD1		THE STORAGTURE AND TITLE OF CHITTENES.											
				11			DON ELCENIOR MI							
B				LL								onth, Day, Year)		
ш		OF CERTIFIED	a	SE OF DEATH (IT	EM 27) (Type, Print))	O.C.M.					onth, Day, Year) 4, 1995		
BE	296. SIGNATURE AND TITLE	OF CHILDREN	COMPLETED CAL					Ε	Mary	► Apı		4, 1995		
B	30. NAME AND ADDRESS OF David R. Fo. 31. DATE FILED (Month, Day,	PERSON WHO	COMPLETED CAL M.D. 32. REGISTR.	11	L1 Penn		0.C.M.	Ε	Mary	► Apı	ril 1	4, 1995		
B	30. NAME AND ADDRESS OF David R. Fo	PERSON WHO	COMPLETED CAL M.D. 32. REGISTR.	11	L1 Penn		0.C.M.	Ε	Mary	► Apı	ril 1	4, 1995		



2. DATE OF DEATH

APRIL

7. DATE OF BIRTH (Month, Day, Year)

14

DECEDENT'S NAME (First, Middle, Last)

C.

5. SEX

DONALD

4. SOCIAL SECURITY NUMBER

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HOURS 212 14 5848 1 2 M 2 | F 74 YRS. June 18,1920 for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR Holy Cross Hospital Silver Spring 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Potomac 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 12210 Glen Mill Road 20854 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puerto Rican, etc.) FORCES? THE YES 2 1 Never Married 2 Married BY 1 TES 2 NO Specify: 3 Widowed 4 Divorced World War COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 18a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Attorney 4 Patent notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William G. Roylance Freda Zender BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဝ Mary Lou Roylance 12210 Glen Mill Road, Potomac, Maryland 20854 hours after death. Page 6 may be Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other place) April 15, 1995 20c. LOCATION — City or Town, State 20a. WE INDO OF DISPUSITION
1 ☐ Buriel 2 🛱 Cremation 3 ☐
4 ☐ Donation 5 ☐ Other (Specify). must funeral director, Montgomery Crematorium, Inc. Bethesda, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery filled in by the flon, or removal. M00689 Avenue, Rockville, Maryland 20850-2805 the medical 23. FART Lifter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or heart failure. List only one cause on each line. cremation, or IMMEDIATE CAUSE (Finel disease or condition resulting in death) and completely fi o burial, cremation event, executed with DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. 9 OUE TO (OR AS A CONSEQUENCE OF). if sny, lesding to immediate been signed by the attending physician at the signed by the and Mental Hygiene prior to 2 cause. Enter UNDERLYING death certificate CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. the MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? that shows any diffease 1 YES 2 THO requires 000 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. AR. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) THE MOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate h filed within 72 hours after death with the State [HOSPLPAL: OTHER: 1 YES 2 4-NO 1 Impetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, TIME OF 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO В 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28 Is 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 🔲 Homicide determined Tem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER D4 9 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RShu -ms 2309 Shorefield hear 32 REGISTRAR'S SIGNATURE 17 1995 Julia Davidson Revolath

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

ROYLANCE

6. AGE (in yrs. last birthday)

IF UNDER 1 YEAR IF UNDER 24 HRS.

615

8. BIRTHPLACE (State or Foreign

Dakota

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 X NO

White

Approximete

interval Betwe

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

DE DEATH?

29d, DATE SIGNEO (Month, Day, Year)

Onset and Death

North

10g, CITIZEN OF WHAT COUNTRY?

United States

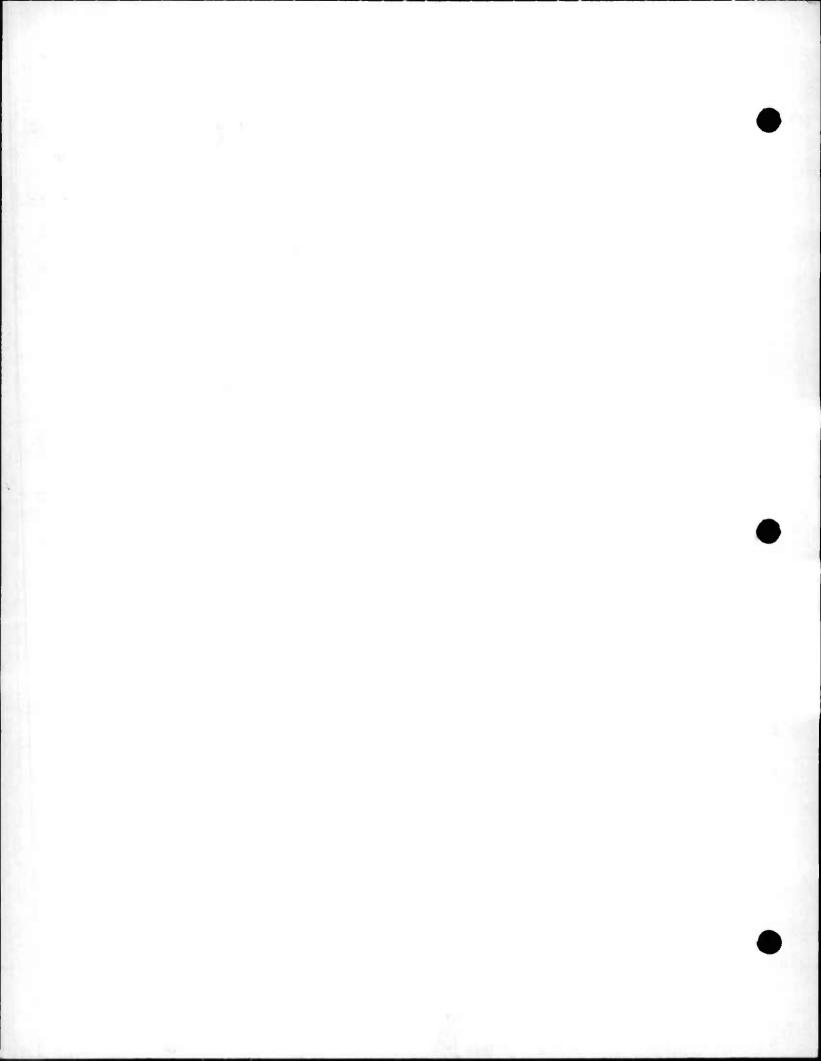
Specify:

9c. COUNTY OF GEATH

Montgomery

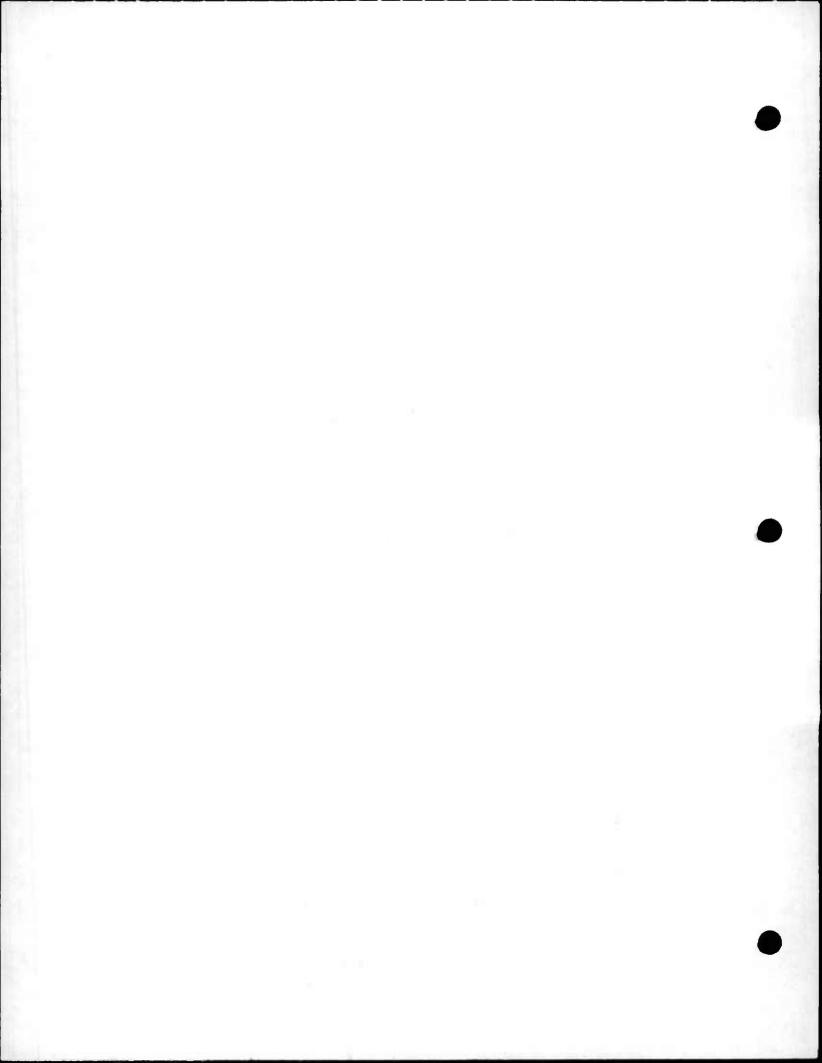
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		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H			SIENE . NO.					
		1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEA	DAY		TIME OF DEATH			
		Louise S. Robe						9, 1995	٥	:00 P			
pin		391.36.2109 Se. FACILITY NAME (If not institution, give s	1 □ M 2 🛣 F 58	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Y	37 N	Country)				
2, 3 should	CTOR	7105 Meadow Lane	treet and number)		Chevy	or location of di	EATN	9c. COUNT	Y OF DEAT				
permit. Pages 1,	DIRE	10a. STATE 10b. COUNTY Maryland Montgo			y, town or Local	se			19d. INSIDE CIT LIMITS? 1 YES 2 (X				
	ERA	7105 Meadow Lan			1 1	20815		100		T COUNTRY?			
5-0020 inding physician. as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	13. WAS DEC	Black, W	American Indian, /hite, stc. White						
ND 21215-0 hospital or attending ached for use as the	COMPLETED B	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	completed)	18e. DECEOENT'S (Give kind of a life. Do NOT us	IT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY 1 of work done during most of working 17 use refined, 1								
AND the hospital detached to	MPL	Clarifornia y Secondary (0-12)	College (1-4 or 5+) +4	Landscap	e Design	ner	D	esigner					
4 9 5 E	S	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, N	leiden Sumame)					
	BE	Charles L. Stov 190. INFORMANT'S NAME (Type/Print)	er	195 MAII ING	ACORESS (Street	Mars and Number or Rural	garet Mi						
2 2 2	임	John T. Roberts				ane Chevy			815				
I IMORE, I. Page 6 may be ral director, page		20a. METHOD OF OISPOSITION 1	oval from State 20th	o. PLACE AND OATE	OF OISPOSITION (Na	ame of	DATE 2	Lexandri	y or Town,				
s AL death ie fune al.		21. SIGNATURE OF FONERAL SERVICE LIC	Petro)		NO ADDRESS OF FA	CILITY Jose	ph Gawle	r's	Sons			
E = 5 9		23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardisc or respiratory strest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. METASTIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Batweet Ones at and Death 3½ years											
Cate be executed thysician and come prior to burial, or traumatic events	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST											
in the state of th	ICAL CE	PART II. Other significant condition	a contributing to death b	out not resulting	in the underlyin	g causa givan in	PI	AS AN AUTOPSY RFORMED?	AVI	FRE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE			
requires been sign f. of Healt	N: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YE	S \square NO \square	1 UNCERTAIN		ES 2 X NO	DF	DEATH?			
De pas	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	TN (Check only one)	J OTTOLKITATI	1						
SICIAN: The Certificate the State	YSI	1 TYES ZYXNO	1 Inputient 2 ER/Out			e 5 🗆 Residence							
문학활	ву рну	27. MANNER OF DEATN 1. Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	V	M 1 .	PRK? YES 2 NO	28d. DEŞCRIBE I	IOW INJURY OCCUP	RED				
CTOR:	ETED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	r — At home, term, s	street, tectory, offic	ry, office 281, LOCATION (Street and Number or Rural Route Number, City or Town, State)							
425	COMPL	one) 2 MEDICAL EXAMINE	CIAN: To the best of my know R: On the basis of examination							d menner ee stated.			
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296. SIGNATURE AND THE OF CERTIFIER	- Ben M	D22775	IBER	29d. DATE S ▶04/2		orith, Day, Year)					
20		30. NAME AND ADDRESS OF PERSON WAS Frederick Barr,				nevy Chas	e, Md.						
0		31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SHA	ATURE									

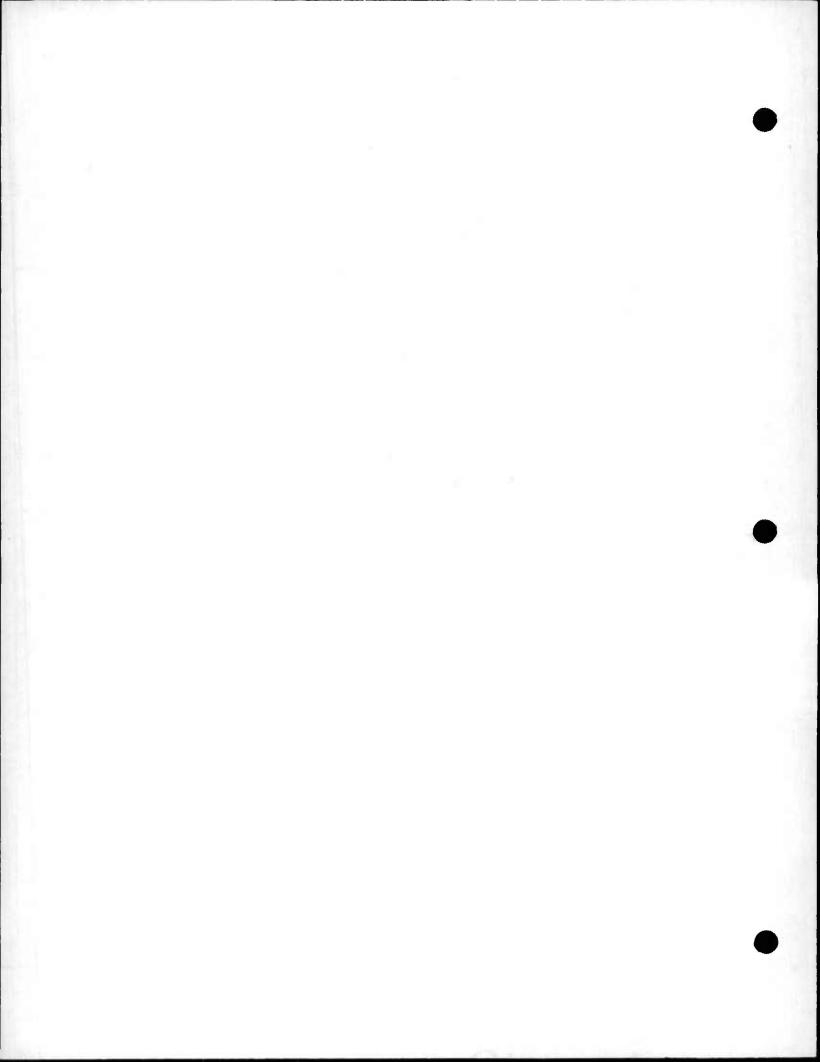


APR 21 1995

		1 - STATE REGISTRAR		STATE OF N	MARYLAN	ND / DE	PARTME TIFICA	NT OF TE O	HEALT F DE	H AND	MENTA	L HYGIEN				
		1. DECEDENT'S NAME (Fire					7				2. DATE	OF DEATH	AY	YEAR	3. TIME	OF DEATH
			nn	Rip]		- 1					Apri	11 19,	1995			:20 A
9		4. SOCIAL SECURITY NUM 217-28-806	3	5. SEX 1	6. AGE (In)		PS. IF UN	DER 1 YEAR		B MIN.	7. DATE (Mont) Apr.	OF BIRTH 1, Day, Year) 20, 1	.902	S. BIRTHI Country SCOT)	State or Foreign
2, 3 should	OR	90. FACILITY NAME (N not Medlantic	Manor 1				100		Spri	ing	EATH			gome		
←*	ן ק	RESIDENCE OF DE	CEDENT							8			Hone	- GOINE		
permit. Pages	DIRECTOR	Maryland	Montg				e. city, tow Silver								LI	SIDE CITY AITS? ES 2 NO
	ERAL	14804 Haro		× III					101. ZIP CO 209				477	ZEN OF W	F WHAT COUNTRY?	
21215-0020 Il or attending physician. for use as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Div		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 MO		If yes,	specify Cu	T OF HISPAI Iban, Mexico IO Specif	n, Puerto F	i? (Specify Yea Rican, atc.)		14. RACE	White,	rican Indien, etc.
215-0 attending se as the	0	15. DE	CEDENT'S EDUC	CATION	16	6e. DECEDE	ENT'S USUAL	OCCUPA	TION		16b.	KIND OF BUS	SINESS/IND			
LAND 2121 the hospital or attended for use once.	PLET	Elementery/Secondary		College (1-4 or 5 -	+)		nd of work do NOT use retire Omemal		most of wo	rking		Own H	Home			
the hospital detached once.	COMPL	17. FATHER'S NAME (First,	Middle, Last)						18. MC	OTHER'S NA	ME (First, A	Aiddle, Meiden				
ज दि द	w	Unknown						Unknown								
retained 5 should notified	8	190. INFORMANT'S NAME				19b, MA	ILING ADDR	ESS (Stree	t end Numl	ber or Rural	Floute Numb	er, City or Town	n, State, Zip	Code)		
	2	Walter R. R	ipley				04 Harold Road, Silver Spring, Maryland 20								20905	
e 6 may be ector, page		20a. METHOD OF OISPOSI 1 🔀 Burlal 2 🗆 Cremati 4 🗆 Donation 5 🗆 Othe	on 3 🗆 Remo	oval from Stata	20b. PL cemete For	LACE AND D	DATE OF DISP	Cem	Name of	v	4/21	Brer	CATION —			
BALTIMORE, hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		21. SIGNATURE OF FUNER.	AL SERVICE LIC	Rhil	esso)		22. NAME 1180	AND ADDI	NESS OF FA	curvHi npshi		nald nue	i Fui		I Home
hours aft ad in by or remo		23. PARY I. Enter the cahock, or I	neert fallure.	complications that List only one cau	t caused the	ha death. h line.	Do not en								In	oproximete terval Between nset and Daat
matin .		disease or condition resulting in death)	→		estiv			ilur	e_						i -	years
8 5 7 8	z			Coro	nary A	Arter	ry Dis	ease	<u>.</u>						110) years
	CATION	Sequentially list condi if sny, lesding to imme				CONSEQUENCE OF):									-	, ,
ate be prior prior	8	CAUSE (Disease or Inj.	ING	Cere	bovas	cular	Acci	dent							3	years
US, P.O. BO) the death certificate be the attending physicial d Mental Hygiene prior injury, or other trau	RTIF	that initiated eventa resulting in deeth) LAS		DUE 10	(OR AS A CO	ONSEQUEN	NSEQUENCE OF):									
at the death by the atten and Mental y Injury, o	CEI	PART II. Other signific	ant condition	e contributing to	deeth but	not result	ting in the	underly	na ceue	a alven In	Part I	24a, WAS AN	ALITODOV	Lan	41505 41	
Z go g z	MEDICAL									givenini		PERFOR	MED?		AVAILAB	JTOPSY FINDINGS LE PRIOR TO TION OF CAUSE H?
E gee e		DID TOBACCO U	JSE CONTI	RIBUTE TO CA	USE OF I	DEATH	YES [NO	Z UN	ICERTAI			11		I 🗆 YE	S 2 NO
N: The lan Ficate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED T	TO MEDICAL	HOSPITAL:	26.	PLACE OF	DEATH (Che		e)							
SICIAN: The certificate the State	YSI	1 TYES 2 THO		1 Inpatient 2	ER/Outpatie	ent 3 🗆 D	OA 4		ome 5 🗆	Residence	8 🗆 Other	(Specify)				
NG PHYSIC fer this ce sath with the marked,	ву Рн	27. MANNER OF DEATH 1 Natural 5 Accident	Pending Investigation	28a. DATE OF (Month, Di		28b	b. TIME OF INJURY M	٧	NJURY AT VORK? YES 2	□ NO	28d. OEŞ	CRIBE HOW IP	JURY OCC	UREO		
TTENDI TTENDI TTOR: A after de	8	3 Suicide 8 Could not be building, atc. (Specify) 28a. PLACE OF INJURY — At home, farm, atreet, fectory, office City or Town, State									ATION (Street e or Town, Stete)	nd Number	or Rural Ro	ute Num	ber,	
	ZE.	290. CERTIFIER 1 X CER	TIFYING PHYSIC	CIAN: To the best of	my knowlede	ce. death ~	ocurred at the	e time de	to and also	co. and de-	to the arm	anin) and —				
Z Z Z =	COMPLET	one) 2 MED	DICAL EXAMINE	R: On the besis of ex											end mai	nner es stated.
THE HOSPI THE FUNER filed within	BE (296 SIGNATURE AND TITLE	OF CERTIFIER	0		29c. LICENSE NUME							Month, E	Pay. Year)		
5 5 3 M	0	111 Wms	1	De me	7				LD	328	17		Apı	cil 1	9,	1995

M. Wajeed Khan, M.D., 12016 Georgia Avenue, Wheaton, Maryland 20902-2004

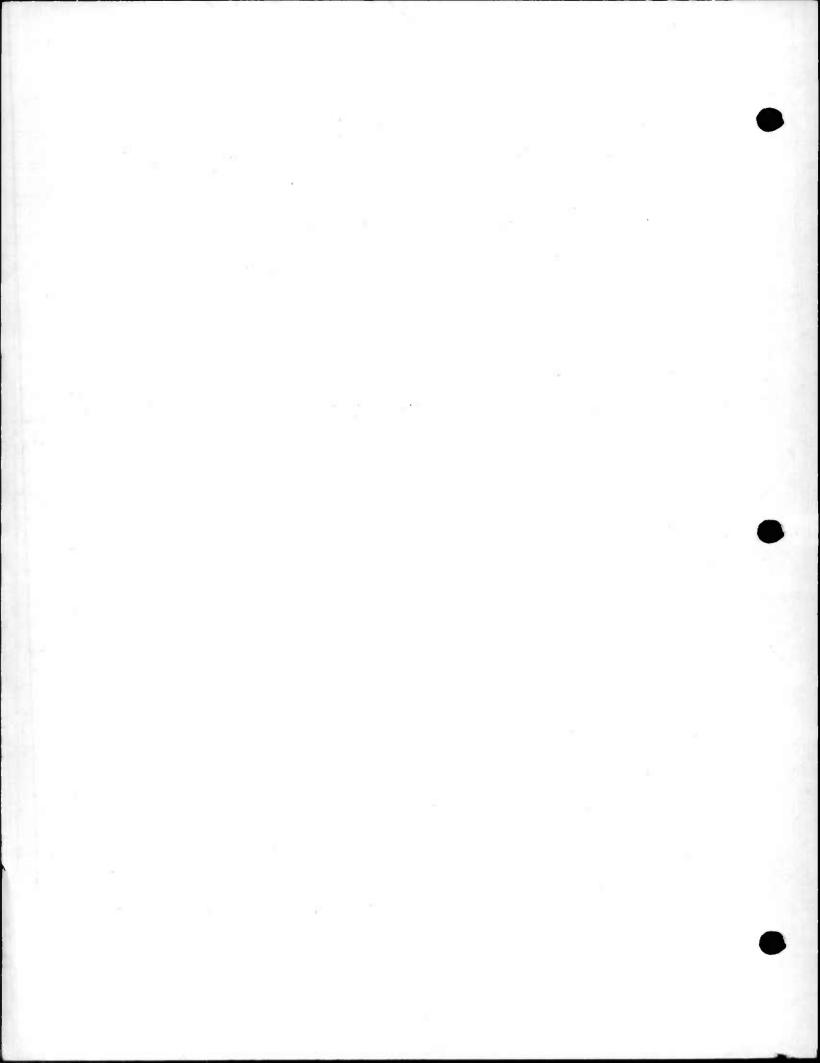
32 REGISTRAR'S GRATURE



APR 21 1995

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/12/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR REDMER PATRICK L. PM 5:59 995 0.44. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS B. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 K M 2 F 214-43-4604 Nov. 8, Maryland Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MONTGOMERY SILVER SPRING HOLY CROSS HO HOSPITAL 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? use as the burial-transit 14901 Lady Meade Circle 20906 USA hospital or attending physician. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 2NO 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexicen, Pu 1 YES 2 NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) detached for Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Page 6 may be retained by the 2 David Milton Redmer Loretta Marie Spigler BE notified funeral director, page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 2 David M. Redmer 14901 Lady Meade Circle, Silver Spring, Maryland Pe 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must cemetery, crematory or other place) Gate of Heaven Cemetery 4/18 Silver Spring, Maryland 4 Donation 8 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home I hours after death. P ted in by the funeral of or removal. 11800 New Hampshire Avenue Silver Spring, Maryland 20904 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, completely filled in by Approximate ahock, or heart feiture. List only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** cremation, the disesse or condition POSITIONAL ASPHYXIA executed within event. reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): and com o bunial, CERTIFICATION traumatic Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING attending physician intal Hygiene prior to certificate be other t CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 the atten PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. requires that the 24e. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and and AVAILABLE PRIOR TO any signed Health a COMPLETION OF CAUSE 1 TYES 2 NO Shows 1 - YES 2 - NO been at. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: certificate has be in the State Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPtTAL: 2 ER/Outpetlent 3 DOA OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 XYES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this . marked, (Month, Day, Ye 4-13-95 1 Natural 4:50 PM 1 YES 2)() NO SUBJECT FELL OFF BED BY After 2 X Accident 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 14901 LADYMEADE CIRCLE 3 Suicide -DIRECTOR: Journ 28 Is 8 Could not be 4 Homicide SILVER SPRING, MARYLAND COMPLET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 0 APRIL 1995 C.M.E 14 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Penn Street, Baltimore, Maryland 21201 111 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The second of the second of
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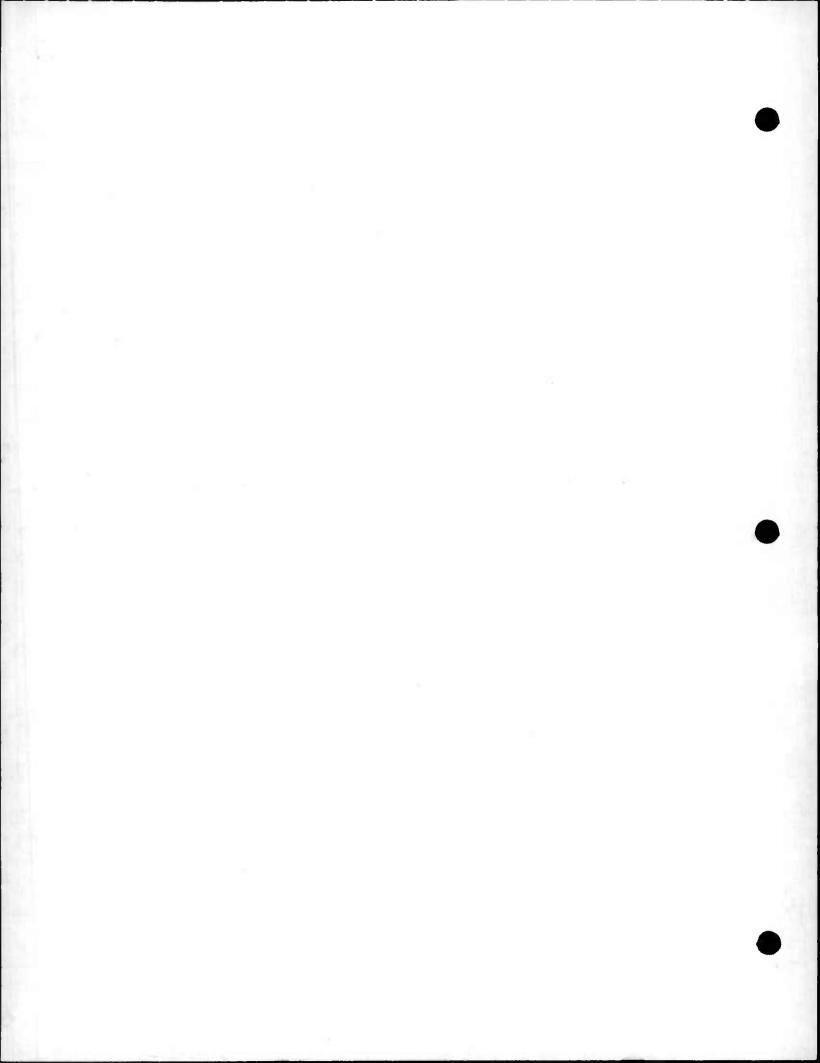
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR DAY April 19 Manuel f. Reider 7:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last hirthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign Country) 1 X M 2 7 F 75 DAYS HOURS (Month, Day, Year) 10-26-1919 294-09-1777 Ohio Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 XYES 2 NO Montgomery Silver Spring permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 20906 funeral director, page 5 should be detached for use as the burial-transit 15107 Interlachen Dr. USA executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

I and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans to burial, cremation, or removal. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 4-YES 2 NO 14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BΥ specify: White 3 Widowed 4 Divorced WWII COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Baker 12 Food/Bajking 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Meyer Reider BE Sarah Wolf notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jeffrey Reider Greentree Rd. Bethesda, Md. 20817 pe 20a. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremailon 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Judean Memorial Garden4/20 4 Donation 5 Other (Specify) Olney, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike RockvilleMd 20852 medical 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death the disease or condition___ WEEKS resulting in death) traumatic event, DUE TO (OR AS A CONSEQUE exhkorelekores ABENC CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to b If any, leading to immediate cause. Enter UNDERLYING attending physician other 1 CAUSE (Disease or Injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atten Mental I PART IN Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and ODRONAKY AROERY DISEASE AVAILABLE PRIOR TO any signed the COMPLETION OF CAUSE 1 TYES 2-NO shows JOHNE DY IVE 1 ☐ YES 2 ☐ NO been x. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h OTHER: 1 TES NO Inpetient 2 - ER/Outpetient 3 - DOA a

Other (Specify) 0 the 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this marked. Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 COMPLETED a Could not be DIRECTOR: Nours after of 28 4 Homicide 29e. CERTIFIER

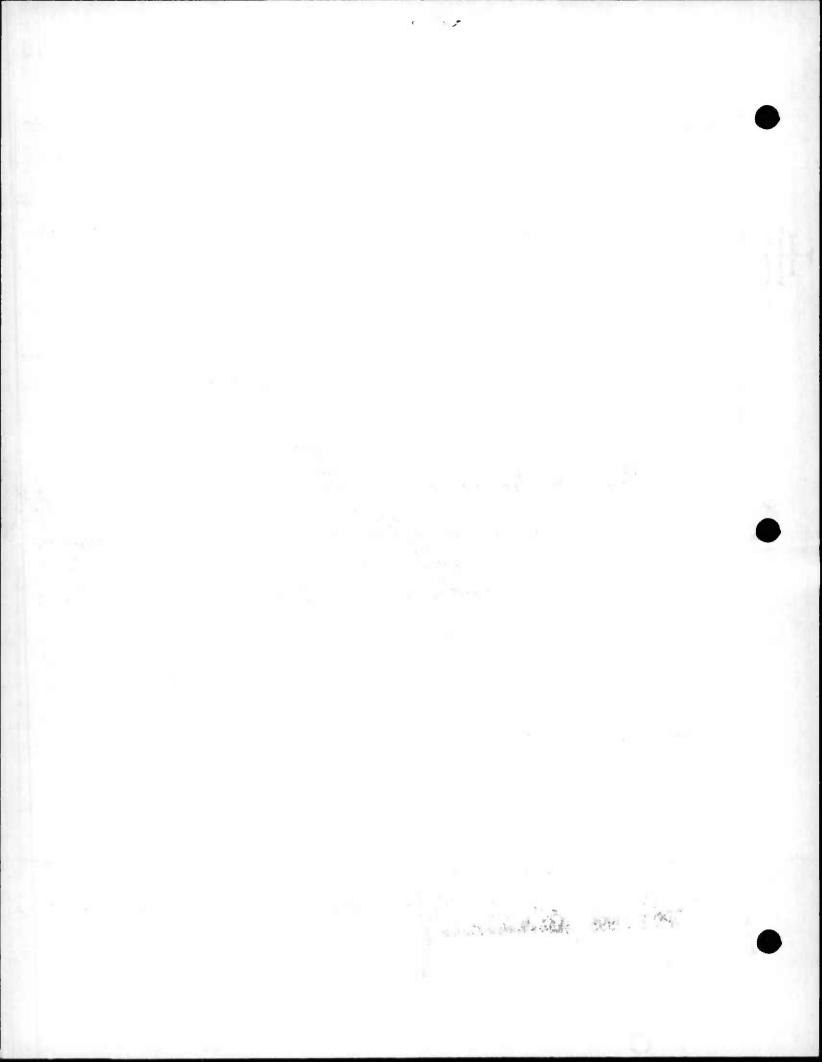
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. FUNERAL Within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 73
IMPORTANT: II 2 MEDICAL EXAMINE nd/or investigation, in my opinion, death occured at the time, data and piace, and due to the cause(s) and manner as stated. 29c, LICENSE NUMBER SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Moghh, Day, Year) BE 200 19195 05568 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH () TEM 27) (Type, Print) 18713 REORAIA AVE. AMUEL ITS COID Z またしかい moo MO 20902 APR 21 1995 m. medigitalis signature



FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Evelyn Mary Reeder 1:25 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Aug. 20, 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS A. BIRTHPLACE (State or Foreign 1 - M 2 X F 234-80-6480 Aug. 1922 W. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington RESIDENCE OF 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 - YES 2 X XNO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 16315 McGregor Drive 21740 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY y/Secondary (0-12) College (1-4 or 5+) 10 Housewife Homemaker notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE (Leonard Treadway Mabel Flora Waldron 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Patricia C. Grams Box 691 - Sharpsburg, MD 21782 Pe 20e METHOD OF DISPOSITION
1 A) Suriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Brownsviile Heights Cemeteny 4/19 ☐ Donation 5 ☐ Other (Specify) Brownsville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eackles-Spencer Funeral Home Harpers Ferry, WV 25425 medicai 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Final event, the disesse or condition resulting in death) executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 other traumatic CERTIFICATION Sequantially list conditions, if sny, laading to Immediata cause. Entar UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be INFIRAL DIRECTOR. After this certificate has been signed by the amendement of the control o CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evants resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 YES 2 W 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 oatlent 2 - ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 5 Pending ВҰ 1 YES 2 NO 28e. PLACE OF INJURY - At he building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicid 29a. CERTIFIER CERTIFYING PHYSICIAN: best of my knowledge, dasth occurred at the time, data end placa, and dua to the cause(a) and manner as stated. = TO THE HOSPITA
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IMPORTANT: II BE 29c. LICENSE NUMBER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



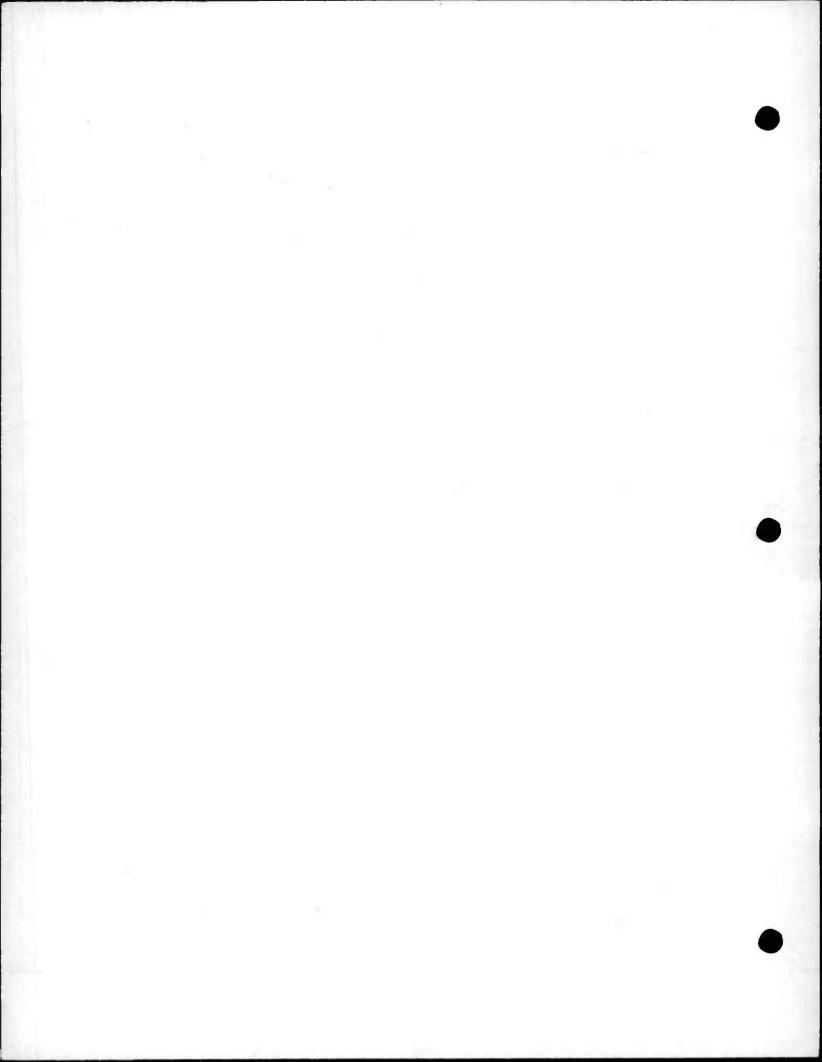
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permit, Pages 1,	DIREC	MD 10e. SYATE 10b. C	Baltimore		10c. CIT	Y, TOWN OR LO		sville			10d. INSIDE CITY LIMITS? 1 [2] YES 2 \(\square\) NO			
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MAR retained to 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) Nirs. Grace A.		19			Alexina Brierley (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pitan Road, Baltimore, MD 21234							
		20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of complete, crematicny or other place) Angel Hill Cemetery 4/21 Havre de Grace, MD												
r death. he funeral. al.	1	21. SIGNATURE OF FUNERAL SERVI	CE LICENSU	24		22. NAM Mito	chell-S	ess of facil Smith		Home	, P.A.			
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signed by Health and Ws any i	MEDICAL	PART ii. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s was an autropsy 24s to												
N: The law required has been State Dept. of I tem 23 sho		DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER?				TH (Check only o		CERTAIN			1 TYES 2 NO			
NG PHYSICIAN: The fiter this certificate sath with the State marked, or item	PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2		28b. TIM	E OF 28c.	INJURY AT WORK?	2	Other (Specify)	INJURY OCCU	JRED			
OR ATTENDING PURECTOR; After hours after death term 28 is man	TED BY	2 Accident Investige 3 Suicide 8 Could in 4 Homicide determin	28e. PLACE C	OF INJURY — At ho	eme, term,		YES 2		Bt. LOCATION (Street City or Town, State		or Rural Route Number,			
TAL OR YAL DIRE	COMPLET		PHYSICIAN: To the best of								d. cause(s) and manner as stated.			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	O BE C	296. SIGNATURE AND TITLE OF CERTIFIER Shows to Carol MO 29c. LICENSE NUMBER 29d. DATE SIGNED/Month, Day, Year) 4//8/95												
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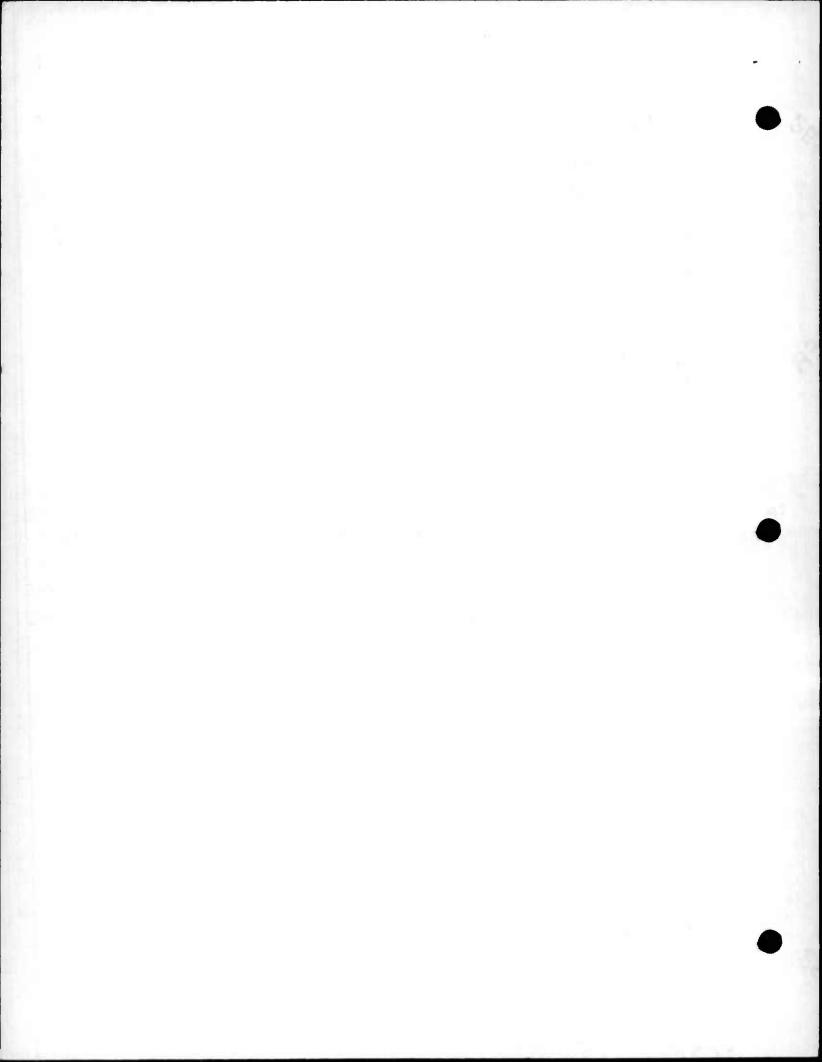
1	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1	. OECEOENT'S NAME (First, Middle, Last)		2. DATE OF DEATH
	LEON DOUGLAS ROEM	1ER	APRIL 13. DAY

		TIEGIO FIANT				LINIII	IOAII	- 01	DLA	111	REG. N	U.				
	1	1. OECEOENT'S NAME (First) LEON DOUGL		(FD						- 1	2. DATE OF DEATH MONTH APRIL 13	DAY 7 O O F	YEAR	3. TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER		5. SEX	A 105 //-							, 1995		6:50AM M		
		222-07-615		5. SEX 1 (2/M 2 F	6. AGE (In yrs.	VRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 4	1014	Country			
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020 physician. burial-transit permit. Pages 1,	5	11. MARITAL STATUS 1 Never Married 2	Married		X YES 2		13.	WAS DEC	ENDENT C	OF HISPANI	C ORIGIN? (Specify , Puerto Ricen, atc.)	fee or No-	14. RACE Black	- American Indian, While, atc.		
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21215-0020 I or attending physic for use as the burial	<u>a</u>	15. DEC	EDENT'S EDUC	ATION	16a. I	DECEDENT'S	USUAL O	CCUPATIO	ON		16b, KIND OF I	USINESS/INC	HISTRY			
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-AND 21215-0020 the hospital or attending physician defached for use as the burial-tran once.	COMPLETED	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOT	HER'S NAM	ME (First, Middle, Msid	en Sumame)				
3 8 A Z	BE	Joseph Roem							F1c	renc	e (Maide	n Name	Unk	nown)		
MARYLAND retained by the hospit 5 should be detached notified at once.	<u>و</u>	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
	-	John A. Manning, Jr. 691 Hances Point Road, North East, MD 21901 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of 200. LOCATION — City of Town. States														
BALTIMORE, safer death. Page 6 may be by the funeral director, page moval.		1 K Buriel 2 Crematio	n 3 🗆 Remov	rel from State	cemetery c	eremetory or o	ther niece)									
Page (Page (all direct		Delaware Veterans Cemetery 4/17 Bear, Delaware 21. SIONATURE OF TWERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home														
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BOX sate be ex hysician a prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING b. Core & Round Law Discusse DUE TO (OR AS A CONSEQUENCE OF):														
fical phy of the property of t	띮	CAUSE (Disease or inju that initiated events	η <u>α</u>	DUE TO	(OR AS A CONS	EOUENCE O	F):									
beath certifical attending phy mtal Hyglene py, or other	F	resulting in death) LAS	T d													
_ # # # # .		BART II Other significa			Taril Faces											
	MEDICAL	PART II. Other algolifica	nt conditions	contributing to	deeth but not	resulting	in the un	derlying	ceuse g	given in F	Part I. 24s. WAS / PERF	ORMEO?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
RECOR requires that een signed by of Health an	ă										1 _ YES	2 🗌 NO		COMPLETION OF CAUSE OF DEATH?		
	- H	DID TORACCO III	CE COLITO	DIETE TO CA				=						1 🗌 YES 2 🗌 NO		
23 Dep lay	AN	DID TOBACCO US		BUIE IO CA		AIH YE			UNC	ERTAIN						
F 2 2 2 5	PHYSICIAN:	EXAMINER?	-	HOSPITAL:			OTHER	2-								
The the	Η	27. MANNER OF DEATH		1 Inpetient 2 I		28b, TIM	-	28c. INJ			Other (Specify) 28d. DESCRIBE HOV	IN HERY CO.	NIDED			
O 등 등 등 등			Pending	(Month, D	ay, Your)		URY M	WO	RK?		200. DESCRIBE NOT	I INJUNT OCI	OHED			
VISION ATTENDING ECTOR: After s after death	ВУ	2 Pulate	nvestigation Could not be	28e. PLACE O	F INJURY — At I	nome, ferm, i	street, fact				28f. LOCATION (Street	t and Number	or Rural Br	puts Number		
DIVISION OR ATTENION SHOUTS after them 28 is	TED		determined	building,	etc. (Specify)		0.004-010				City or Town, Ste	(e)	01 710107710	, and training,		
DIVISION TO THE HOSPITAL OR ATTENDING IN THE FUNERAL DIRECTOR: After be filed within 72 hours after death IMPORTANT: It item 28 is man	COMPLET	29e. CERTIFIER	IFYING PHYSICI	AN: To the heat of	mu knowledge	double conver	4 - 4 15 - 44				o the ceuse(e) end n					
PITAL BRAL 172	N N													and manner as stated		
HOS!		296. SIGNATURE AND TITLE		_			120						f due to the couse(e) and manner ee stated.			
를 를 해 8	B		5	7	1					ENSE NUMI	BER	29d. DAT	E SIONED	(Month, Day, Year)		
₽ ₽ ₽ 2	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH OT	EM 27) / Type	Prints		D3	2395		1	7-13	1.42		
	1	THOMAS FINUCAN 3 MAULDIN AVENUE NORTH EAST, MARYLAND 21901														
		31. DATE FILED (Month, Day, 1	(bar) 1005	32. REGISTRA	R'S SIGNATURE	E NO.	KIN I	umo I	PIA	KILHI	VD 21301	-				
		APR 1	4 1995	Julia di	H'S SIGNATURE	ardall								1		
				1/												



•	1	FOR STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR ERTIF	TMENT	T OF H	EALTH	AND N	MENTA	L HYGIEN		0	13051	
		1. DECEDENT'S NAME (First,	a	Mari	е				R	ic	e	2. DATE	OF DEATH	3 4	95	TIME OF DEATH	
9	i.	4. SOCIAL SECURITY NUMBER 213-30-12		5. SEX 1 M 2 F	6. AGE (in yrs. les	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	MIN.	(Mont	OF BIRTH th, Day, Year) 26 19	932	8. BIRTHPLACE (State or Foreign Country) Maryland		
2, 3 should	5	99. FACILITY NAME (# not ins Carroll Co	unty		1 Hc	spi	ta1			nins	on of DE	ATH			rro1		
l. Pages 1, 2, 3 g	2	RESIDENCE OF DEC	10b. COUNTY					Y, TOWN C							1	Od. INSIDE CITY LIMITS?	
~	III.	Maryland	Carr	011			we	stmi		ZIP COD	E			10g. CITI		☐ YES 2 NO	
20 Nysician. urial-transit perm		134 Smith	Avenu	12. WAS DECEDEN	IT EVER IN	U.S. ARI	MED	13		2115		ic onicii	N? (Specify Yes			States	
O 5 4 a	5	1 Never Merried 2 Nover 3 Never Merried 2 Nover 3 Never Merried 2 Never 3 Never Merried 2 Never Merried 3 Never Merried 2 Never Merried 3 Never Merried 2 Never Merried 3 Never Merried 2 Never Merried 3 Never Merried 2 Never Merried 3 Neve	ced	FORCES? 1	YES	2 V N	0		If yes, spe	ecity Cube	n, Mexicen	, Puerto	Rican, etc.)	or No —	or No- 14. RACE — American Indian Black, White, etc. Specify: White		
		15. DECE (Specify only Elementary/Secondary (0-	DENT'S EDUC highest grade (ATION completed) College (1-4 or 5	+)	(Gi	CEDENT'S we kind of w Do NOT us	vork done	CCUPATIO during mo:	N st of workin	ng	168	. KIND OF BU	SINESS/IND	USTRY		
the hospital or detached for u		12	2 Homema!										1/a Middle, Maiden			·	
1 8 G 4		William					Ма	vis	N	Marie	F	orre	st				
40 (0)) c	Stanley Cu		Rice						(Street and Number or Rural Route Number, City or Town, State, Zip Code) h Road, Westminster, MD 211							
THE PART OF PA		20e, METHOD OF DISPOSITION TX Spuriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery 4/17/95 Westminster, MD															
ALTIMO death. Page 6 tuneral direct J. examiner mu		21. SIGNATURE OF FUNERAL		ENSEE	_ 108	eer	Par	22.	NAME AN	D ADDRES	SS OF FAC	ILITY	L Home				
w - 8 = 0		Kothere	KD 4	Pritts - 5	Suci	tur	^	4	412	Was	hind	rtor	n Rd.	. Wes	stmi	nster, MD	
of filled in the mentation, or intermediate.		interval Between Onset and Des Cause or each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in deeth) a. Electromechanica Dissociation 40 miles												Approximate interval Between Onset and Death			
P 00 00		Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury) DUE TO (OR AS A CONSEQUENCE OF): POSPINATORY AFFREST Z6 hrs 26 hrs 27 hrs 28 hrs 29 hrs 20 hrs												26 hrs			
BOX 68 ficate be execut physician and c ne prior to buris er traumatic														26 hrs			
oth oth		that initiated events reaulting in death) LAST		Car	ala Ala	CONSEC	consequence of: Aprest									26 hrs	
E 8 9 9		PART II. Other algnifican	t conditions	contributing to	death bu	at not re	suiting i	n the un	derlying	ceuse g	jiven in F	Part i.	PERFOR	MED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE	
HEC equires of Hea MET		DID TOBACCO US	E CONTR	IDLITE TO CA	LICE OF	E DE AT	TU VE	c the	10 0	11216	FREALA		1 TES 2	E NO		F DEATH?	
- 10000		25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		- 1	26. PLACE	OF DEAT		only one)	UNC	ERTAIN						
OF VIT, PHYSICIAN: Th this certificate with the State ked, or item		1 VES 2 NO		HOSPITAL: 1 Inpatient 2 26a. DATE OF (Month, Di	INJURY	atlent 3	28b. TIME	4 - Nurs	aling Home	RY AT	sidence 8		r (Specify)	NJURY OCC	URED		
Ming P Marter of Marty Ma Marty Marty Marty Marty Marty Marty Marty Marty Marty Marty Mart		2 - 2-1-14	rvestigation	28e. PLACE OF		- At bon	INJI	M		ES 2 [-	201.100	471041 (0)				
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State I Item 28 is marked, or item PLETED BY PHYSICIA		4 Homicide	could not be etermined	building,	etc. (Speci	(y)		over, rech	ory, office			City	ATION (Street a or Town, State)	and Number (or Rurel Riou	te Number,	
				IAN: To the best of												nd menner ee stated.	
THE H fled v		SIGNATURE AND TITLE (OF CENTIFIER	1800						29c. LICE	NSE NUME	BER 9	6	29d. DATE	SIGNED (M	lonth, Day, Year)	
₽ ₽ ₽ ¥		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Ricketts MD Westminster MD 2-1157															
. 0		11. DATE FILED (Month, Day, Ye	Julia Salia	32. REGISTRA)'S SIGNA		21 /i	7112	> ^		10		4		_		

31. DATE FILED (Month, Day, Year)
APR 1 7 1995



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

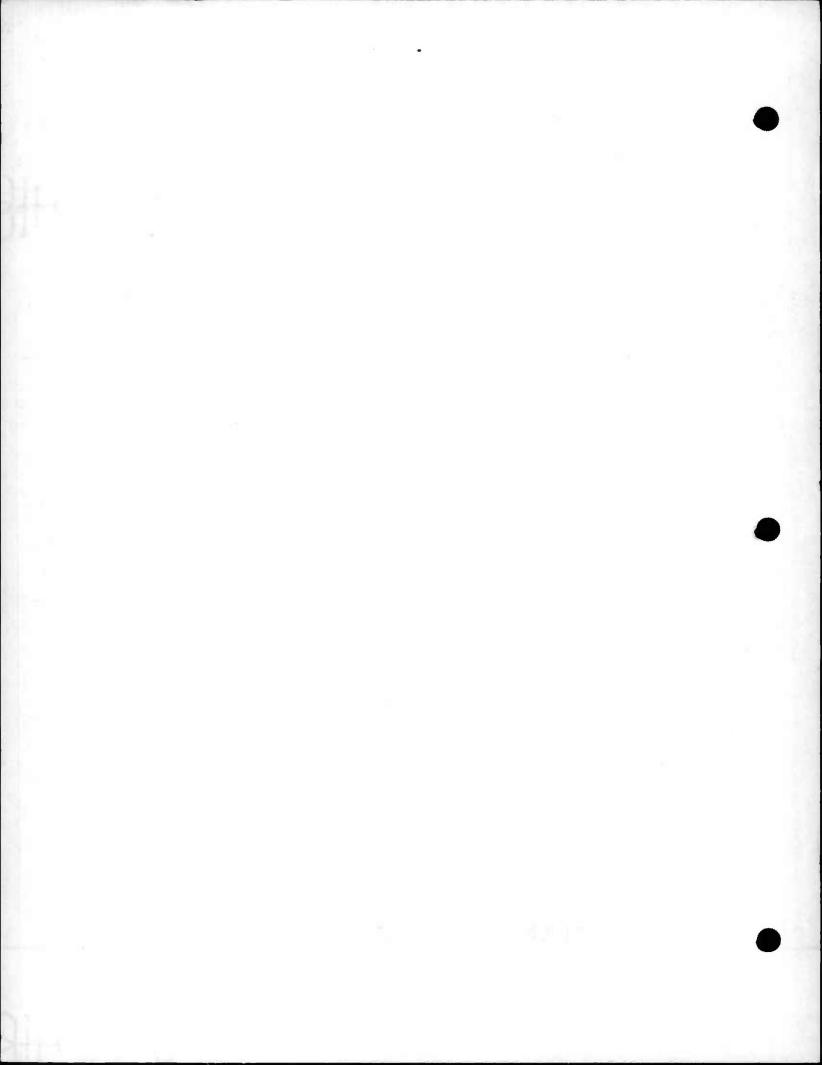
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an experient leads. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF DEATH	REG. NO.

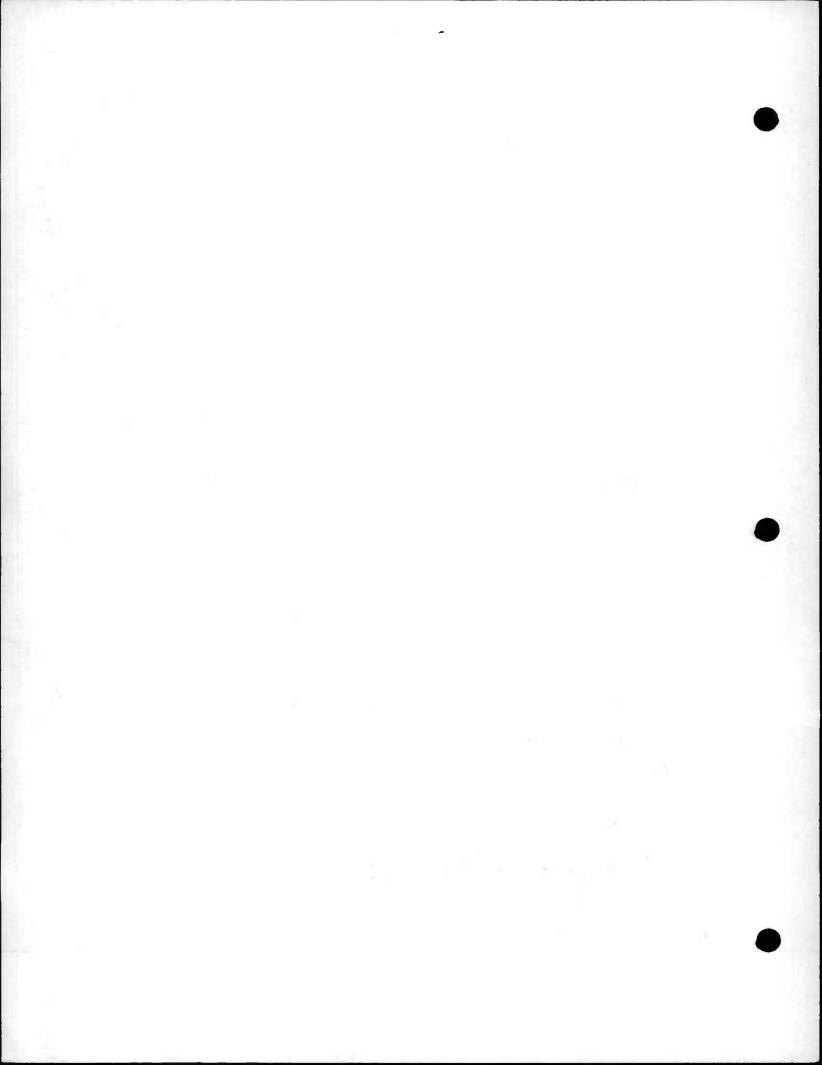
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		TMENT OF H		MENTAL HYGIENE							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH					
	William Chester	Sherwood				04 TH 23	1995	18:30 рм					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign intry)					
	236-12-3988	1 ⅓ M 2 □ F 8 I	L YRS.	MONTHS DAYS	HOURS MIN.	July 4, 19		īV					
~	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN C	OR LOCATION OF DE	EATH	9c. COUNTY OF	DEATH					
DIRECTOR	Garrett County M	emorial Hospita	1	0ak1a	and		Garr	ett					
) E	10e. STATE 10b. COUNT	Y .	10c, CITY	, TOWN OR LOCAT	ION			10d. INSIDE CITY					
ā	MD Ga	rrett	0a	kland				LIMITS? 1X YES 2 NO					
₹ I	10e. STREET AND NUMBER			101	ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?					
FUNERAL	7th & Alder Stre				21550		USA						
E	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. FORCES? 1 X YES 2				NC ORIGIN? (Specify Year in, Puerto Rican, etc.)	or No — 14. RA Bir	CE — American Indian, ick, White, etc.					
Β¥	3 Widowed 4 Divorced	WWII		1 TYES	2 NO Specif	y:	Sp	ochy: White					
8	15. DECEDENT'S EDI	UCATION 18a.	DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUSI	INESS/INDUSTRY						
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during mo e retired.)	st of working			77"					
MPI	12	Ca	r Pain	ter		Gene	ral Mot	ors					
흥	17. FATHER'S NAME (First, Middle, Last)		_		18. MOTHER'S NA	ME (First, Middle, Maiden S	iumame)						
BE	William Sherwood					a Taylor							
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town							
	Vera Sherwood			ar Koad		ller, MD 2							
	1 X Burial 2 Cremation 3 Ram 4 Donation 8 Other (Specify)	noval from State cemetery.	orematory or on OF Cem	her niece)		1995 E1k G	CATION — City or						
	21. SIGNATURE OF FUNERAL SERVICE L		or cem	22. NAME AN	D ADDRESS DF FA	CILITY		WV					
	· David r	2 Durdock				ock Funeral Kitzmiller		1538					
	23. PART I. Enter the diseases, pr	complications that caused the	death. Do n	ot enter the mo	de of dying, auc	h as cardlec or respir	atory errest,	Approximate Interval Between					
	IMMEDIATE CAUSE (Final												
	disease or condition a. PNEUMUM a DUE TO (OR AS A CONSEQUENCE OF):												
		DUE TO (OR AS A CON	SEQUENCE OF):	(
NO N	Sequentielly list conditions,	b. COVOVAU	SEQUENCE OF	v tel	14 91	sease		yeux					
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	Domes	-> (1	<i>y</i> .	•			YPUVC					
표	CAUSE (Disease or Injury that Initiated eventa	DUE TO (OR AS A CON	SEOUENCE OF):				10115					
F	resulting in death) LAST	d											
2	PART II. Other significent condition	ns contributing to death but no	ot consisting is	n the underlying	n seven shan in	Boot I Los uno aus	urmanau I a						
CAL		- Contributing to death but he	or resorting in	n the underlying	J cause given in	Part I. 24s. WAS AN A PERFORM		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE					
MEDIC						1 TES 2	□ NO	OF DEATH?					
Σ	DID TOBACCO USE	CONTRIBUTE TO CA	USE OF	DEATH Y	YES IT NO			1 TYES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				ACE OF DEATH (Ch								
SIC	EXAMINER? 1 YES 2 ZNO	HOSPITAL: 1 Linpstient 2 ER/Outpetlant	3 DOA	OTHER:		8 Other (Specify)							
ξ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HOW IN	JURY OCCURED						
BY F	1 Natural 5 Pending 2 Accident Investigation	(MONTH, Day, 1981)	INS		RK? /ES 2 NO								
	3 Suicide 8 Could not be	28a. PLACE OF INJURY At building, etc. (Specify)	home, tarm, s	treet, factory, office		28t. LOCATION (Street ar City or Town, State)	nd Number or Rure	I Route Number,					
	4 Homicide determined												
COMPLETED		SICIAN: To the best of my knowledge,	death occurre	d at the time, date	and place, and due	to the cause(a) end menr	ner ea stated.						
Š	one) 2 MEDICAL EXAMIN	ER: On the beels of examination end	or investigation	n, In my opinion, d	eath occured at the	time, date end place, and	due to the cause	e(s) and mennar ea stated.					
ш	296. SIGNATURE AND TITLE OF CENTIFIE	R (3)	27		29c. LICENSE NUI	MBER	29d. DATE SIGN	ED (Month, Day, Year)					
TO B	Valle	us/luc	CC		1+20	0154	× 41	24/95					
-	30. NAME AND ADDRESS OF PERSON W												
	P. Daniel Millo 31. DATE FILED (Month, Day, Year)			. Lake F	Park, MD								
	APR 24 1	995 Jalia disede	Rad										
	WILL MAN	John Marie		•									



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
		Laura	Leedar	re SH	HANHOLI	Z					April				7:30 P M
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs	lest birthday			IF UNDER		7. DATE OF	BIRTH		S. BIRTHP	LACE (State or Foreign
D		220-07-647		1 🗌 M 2 💢 F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	Apr.	4, 1	916	West	t Virginia
pjnous	_	9e. FACILITY NAME (If not in	astitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	EATH		9c. COU	NTY OF DE	ATH
1, 2, 3	DIRECTOR	Garrett Co		<u>lemorial</u>	Hospit	a1		0a	kland	1				Garre	ett
Pages 1	2	10e. STATE	10b. COUNTY	1		10c. C	TY, TOWN	OR LOCA	TION					1	IOd. INSIDE CITY
₹.		WV		Presto	n		7	Cerr	a Alı	a				_ .	YES 2 X NO
permit.	FUNERAL	10e. STREET AND NUMBER						10	H. ZIP COO	E			10g. CITI	ZEN OF WI	IAT COUNTRY?
DZO physician. burial-transit	買	HC 82, Box	114			_				2	6764			USA	A
Aysicii urial-t	<u>E</u>	11. MARITAL STATUS 1 Never Married 2	Merried		YES 2						NIC ORIGIN? (ar No-	14. RACE - Bleck,	- Americen Indien, White, elc.
2 g g	B	3 Widowed 4 2 Olvo		IF YES, GIVE Y	MAR OR DATES			1 YE	S 2 XNO	Specify	y:			Specify	White
r attend	윤		EOENT'S EDU		18a.	DECEDENT	S USUAL O	CCUPATI	ION lost of working	27	16b. KI	ND OF BU	SINESS/IND	USTRY	
E 5	COMPLET	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT	use retired.)			~					
the hospital detached for	₩	12					Secre	etar	-					Age	ncy
t once.	8	17. FATHER'S NAME (First, M	,								ME (First, Mick		Surname)		
ed by t	8	Robert L.		<u>n</u>		Direct Arrives	- union				Jane			-	
IMORE, MARTLAND Page 6 may be retained by the hospit il director, page 5 should be detached ner must be notified at once.	욘	Dorothy J.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7							Aoute Number, a Alta				ia 26764
AE,	H	20e. METHOO OF DISPOSIT	ION		20b. PLA	CE AND OAT	E OF OISPOS	SITION (N	lama ol	CII	OATE			City or Tow	
ALIIMORE, death. Page 6 may b funeral director, pag examiner must be		1 Donation 8 Other		oval from State	cametery.	cremetory or lega C	remat	ory			4/20	100			
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
death death fune		► Bda	A. D	Wars	~)						eral H		.1 1	MD	21550
hours after death. ed in by the funera or removal. medical exami		23. PART I. Enter the d	iseases, or o	complications the	et caused tha	death. Do	not enter	the m	Ode of dv	econ	d St.	or read	ratory arr	, MD	21550
ited within an nours after completely filled in by the ial, cremation, or remov-		ahock, or h IMMEDIATE CAUSE (Fir	eert fellure.	List only one cer	use on eech	line.			,				,	,	Interval Between Onset and Death
within 27 within 27 ppletely fille cremation,		disease or condition esulting in death) . Acute Renal Failure													48 hours
ed within ompleteh ompleteh II. crema		DUE TO (OR AS A CONSEDUENCE OF):													
executed within and completel to burial, crems	Z	Sequantielly list condit	lana C	. Hypote	nsion	& Sho	ck								4 days
UA 08 e be execut sician and c nor to bunic traumatic	탈	if any, leeding to imme cause. Enter UNDERLY	diata		(OR AS A CON		·								
ertificate be ing physician rgiene prior t	윤	CAUSE (Disease or inju		c Conges	COR AS A CON			re							2 Years
. 0 PE =	CERTIFICATIO	that initiated events resulting in deeth) LAS	т	d. Emphys			.,,								0. **
the death the atter Mental	핑														2 Years
that the dea ed by the at th and Menti any Injury,	MEDICAL	PART II. Other significe										LE. WAS AN PERFOR		1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
es the	ă	ABnormal o		y middle	lobe .	left :	Lung,	ost	teoar	thri	tis 1	YES 2	X NO		COMPLETION DF CAUSE DF GEATH?
requires seen sign of Heal		Osteoporos DID TOBACC		CONTRIBLIT	E TO C	Alice C	E DEA	TH	VEC VI	A NV			,	1	I □ YES 2 NO
AL RECORDS he law requires that the di e has been signed by the is te Dept. of Health and Mer m 23 shows any Injury	AN	25. WAS CASE REFERRED TO		CONTRIBUT	2 10 0	403E C	T DEA			_					·
SICIAN: The certificate h the State h	SICIAN	EXAMINER?	o meorale	HOSPITAL:	☐ ER/Outpatien	3 🗆 DOA	OTHE!	R:			8 Other (S	Speciful			
YSICIA S certifi th the	РНУ	27. MANNER OF DEATH		28e. DATE OF (Month, E	INJURY	28b. Ti	-	28c. IN	JURY AT		28d. DESCR		NJURY OC	CURED	
NG PHYS fler this eath with	ВУ		Pending Investigation	(IMOND), E	Jay, Idai,		M		YES 2	NO					
N A P S			Could not be	28a. PLACE C building,	OF INJURY — A atc. (Specify)	t home, farm	, street, fac	tory, offi	Ca		281. LOCATI City or	ON (Street of Town, Stete)		or Rural Ro	ute Number,
OR ATTE DIRECTO hours after item 28	5	an organization /													
RAL D 72 hg	COMPLETE	(Check only		CIAN: To the best of											end manner ee stated,
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: It		29b, SIGNATURE AND TITLE			<i>f</i> =	vezuya	my (-preside,	-			w pieca, ar			
구는 기를	出	11/1/4	A. M.	10	Kun	(11			ENSE NUI			29d. DAT		Month, Day, Year)
₽ ₽ 2 ₹	2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETEO CALL	SE OF DEATH	ITEM 27) (74)	oe, Print)		ָט.	2665	U			4/19	/ 95
		Margaret A.			D Box 4			nd M	íD 21.	550					
		31. DATE FILED (Month, Day,	Year)	32. REGISTRA	AR'S SIGNATUR	E		1	<u> 21</u>	000					
	1	APR 21	1995	Jalia Sau	ichor Ro	dall									

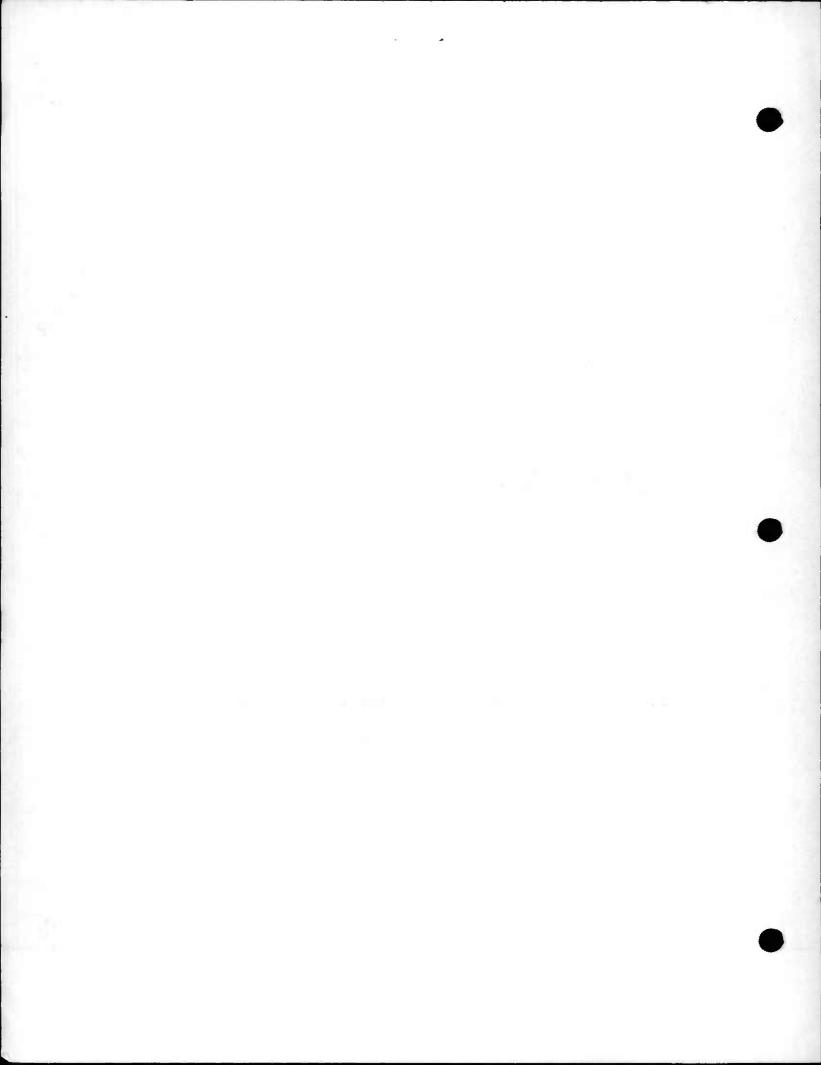


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	to the concept, which has been so been signed by the attentional physical and completely in the control of the
---	---

	1 - STATE REGISTRAR	STATE OF I		DEPAR					IENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATN			3. TIME OF DEATN
	Julia Jane	SHAFI	FER						April 16		YEAR 5	1:30 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. less	t birthday)	IF UNDER		IF UNDER 2	4 HRS.	7. DATE OF BIRTH		6. BIRTHI	PLACE (State or Foreign
	220-34-1935	1 🗌 M 2 💢 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) Aug. 25,	1907	Mar	yland
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN OR	LOCATIO				NTY OF DE	7
S S	Cuppett-Weeks N	ursing Ho	me				0al	k1an	d	Gar	rett	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	7		1 40 000	Y. TOWN O							
DIRECTOR				10c. CII	, , , , , , ,							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	arrett			0	ak1a:	nd IP CODE			40- 0171	2511.05.11	1 YES 2 TYNO
RA	797 Crellin Min	- D1				101. 2		0				
FUNERAL	11. MARITAL STATUS		IT EVER IN U.S. AR	MED	13. V	WAS DECE		1550	C ORIGIN? (Specify Yes	or No	US.	A American Indian,
	1 Never Merried 2 Married	FORCES? 1	YES 2 X N	10	11	yes, spec	Ify Cuban,	Mexican	, Puarto Rican, atc.)	01.10	Black	, White, etc.
ВУ	3 🕅 Widowed 4 🗌 Divorced					_ 120 2	(A)	Specify.			аресп	White
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	/G/	CEDENT'S	vork done d	CUPATION	of working		16b. KIND OF BUS	INESS/IND	USTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5	H4m	Do NOT us	e retired.)							
d de	9			_	Hous					Home		
-	17. FATNER'S NAME (First, Middle, Last)	T					_		NE (First, Middle, Maiden	,		
BE	Charles	Lantz	1 400	44444		-01		ora			Shaf	fer
2	Charles T. Shaf	for							Oute Number, City or Tow			01550
3	20e, METHOD OF DISPOSITION	rer	20b. PLACE A					oad,	Oakland,	Mary CATION -		
2	1 N Burlet 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	novat from State	cametery, crei	matory or of	her place)		e or		1			
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	- [Marora	a cei	22. 1	NAME AND			ILITY	rora,	wes	st Va.
	D. 100 0	DA. A.D							al Home			010
	22 PART I Fried the disease	- CUMBY							St., Oakl			
	23. PART I. Entar tha diseases, or ahock, or heart failure.	List only one car	it caused the de use on each line	ath, Dor	ot enter	the mode	a of dyln	g, such	as cardiac or respi	ratory arr	ast,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disesse or condition	Ar	ichi									Onset and Death
	resulting in death)	S. DUE Y	OR AS A CONSEC	NIENOE O								3 years
	_	7	TARED	JUENCE UI	-):							31,20
ō	Sequentially list conditions,	b. DUE TO	(OR AS A CONSEC	DUENCE OF	1 :							- grans
\f	If any, leading to immediate cause, Enter UNDERLYING	6										į l
Ē	CAUSE (Disesse or Injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	ን:							
CERTIFICATION	resulting in death) LAST	d										
	PART ii. Other aignificant condition	ns contributing to	death but not re	eaulting	n the un	derlylna	cause of	ven in E	Part i. 24a, WAS AN	AUTOBOV	1 245	WERE AUTOPSY FINDINGS
CAL						scriying	oudou gi		PERFOR	MED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI									1 YES 2	Suo		OF DEATH?
Σ	DID TOBACCO USE	CONTRIBUT	E TO CAU	SE O	DFA'	TH Y	ES 🖂	NC	1			1 NES 2 NO
N N	25. WAS CASE REFERRED TO MEDICAL								ck only one)			
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	1:			Other (Specify)			
<u>.</u>	27. MANNER OF DEATH	26a. DATE OF	INJURY	28b. TIM	E OF	26c. INJUI	RY AT	Tourist Control	28d. DESCRIBE NOW I	NJURY OCC	CURED	
ВУР	1 Natural 5 Pending 2 Accident investigation	(Month, E	lay, 10ar)	INJ	URY M	WOR	(? S 2 [ND				
ED B	3 Suicide 6 Could not be	28e. PLACE C	F INJURY A1 hor	me, ferm, a	rireet, facto	ory, offica			26f. LOCATION (Street	and Number	or Rural R	oute Number,
	4 Nomicide determined		oral (opoony)						City or Town, State)			
COMPLET	29a. CERTIFIER (Check only	SICIAN: To the best of	my knowledge, da	ath occurre	d at the th	me, date a	nd piace, e	end due t	o the cause(a) and mer	ner ea stat	ed.	
O	one) 2 MEDICAL EXAMIN											end manner as stated.
	296. SIGNATURE AND TITLE OF CORTIFIE	R					29c. LICEN	ISE NUM	BER	29d. DATI	E SIGNED	(Month, Day, Year)
) BE	(from a)						T.	>33	464	•		195
일	30. NAME AND ADDRESS OF PERSON W	/ 3 1 1	SE OF DEATH (ITER	M 27) (Type.	Print)				F - /		1110	
	(fobert /h	Coughhn	Mo	r	م ال	18		55W	LW 267	16		
/	31. DATE FILED (Month, Day, Year)		AR'S SIGNATURE	7								
110	APR 1 9 1995	Vila offer	ichen-Rand	all								



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 7Z hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ဥ

30. NAME AND ADDRESS OF PERSON

31. DATE FILED (Month, Day, Year)

APR 1 9 1995

Dr.

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thomas Johnson, MD 311 N. Fo

LED (Month, Day, Year)

APR 1 9 1995

APR 1 9 1995

			•	1						5) 3	10000	
	FOR 1 - STATE REGISTRAR	STATE OF N	IARYLAND C	/ DEPAR	ITMEN	T OF H E OF	EALTH DEAT	AND I	MENTAL HYGI REG.				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	1 DAY	YEAR	3. TIME OF DEATH	
	Lester Will:	iam S	SWEITZEF	R					April 1			7:00 P M	
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la:	ast birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH		9. BIRTHP	PLACE (State or Foreign	
	220-10-1067	1 🔀 M 2 🗆 F	81	YRS.	MONTHS	DAY8	HOURS	MIN.	June 12,		Mars		
	9a. FACILITY NAME (# not institution, give st	ireet and number)		F- 7	9b, CIT	Y, TOWN O	R LOCATI				Mary INTY OF DE		
SH	Garrett Co. Memo	orial Hos	anital	ł		0akl					Garre		
CT	RESIDENCE OF DECEDENT		Proce			- Curre	-				Garre	:	
RE	10a. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY LIMITS?	
٥	MD	Garrett							Swanto	n		1 TES 2 KNO	
AL	10e. STREET AND NUMBER					101.	ZIP CODE	Ē		10g. CIT	IZEN OF WI	HAT COUNTRY?	
EA	P.O. Box 105							2	1561		USA		
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. AF	RMED	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Specify	Yee or No-	14. BACE	— American Indian	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W		NO		It yes, spe	ecify Cuber	n, Mexicar	n, Puerto Ricen, etc.)		Black, Specify	White, atc.	
	=	ı										White	
19	15. DECEDENT'S EDUC (Specify only highest grade of	CATION completed)	16a, Df	ECEDENT'S	USUAL C	CCUPATIO	N of workin		16b. KIND OF	BUSINESS/INC	DUSTRY		
3	Elementary/Secondary (0-12)	College (1-4 or 5+) life	Give kind of view. Do NOT us									
MP	6			Bra	akema	an			В	&O Rai	ilroad	d	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAI	ME (First, Middle, Mail	den Sumeme)			
BE (Truman	- Sw	eitzer	4 <u> </u>				Jess	sie -		Mo	osser	
2	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a)	nd Number	or Rural R	Toute Number, City or	Town, State, Zip	p Code)		
F	Melvin Sweitzer			Rt.]	L, Bo	ox 31	-A,	Swan	nton, Mar	vland	2156	61	
	20s. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Remo	of down State	20b. PLACE	AND DATE	OF DISPOS	SITION (Nar	_			LOCATION -			
	4 Donetion 5 Other (Specify)	Will from Stine	- cemetery, cre	ematory or or e	ther plece) Ceme	terv			4/18 St	zant (n	Mar	wland	
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENGRE			22.	. NAME AN	ID ADDRES	SS OF FAC	CILITY	vaiicon	, Ital	yland	
	▶ 12. 11 h	Mass!							ral Home				
	· Scart F.	Samo				<u>32 S</u>	. Sec	cond	St., Oal	kland,	MD	21550	
	23. PART I. Enter the diseases, or contains abook, or heart fellure. L	Int Driv Dra cau	caused the da se on each line	aath. Dor a.	1Dt anter	/ tha mpo	da of dylr	ng, such	n aa cardlac or re	apiretory an	reat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final											Onset and Death	
	disease or condition resulting in death)		rovascu]			lent						Immediate	
	1		(OR AS A CONSE		F):								
No.	Sequentially list conditions,		tension								Years		
Ĕ	If any, leading to immediate cause. Enter UNDERLYING		OR AS A CONSE										
5	CAUSE (Disease or Injury		tes Mell									Years	
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO ((OR AS A CONSE	OUENCE OF	ř):								
則	d	J											
	PART II. Other algolficant conditions	a contributing to	death but not	reaulting	In the ur	ndariying	Cause o	lven in f	Part I. 24s. WAS	AN AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS	
<u>র</u> ∥									PERI	FORMED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									1 □ YES	2 (X NO		OF DEATH?	
Σ											1 1	1 TES 2 NO	
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL												
길	EXAMINER?	HOSPITAL:			OTHER		ACE OF DE	ATH (Che	ck only one)				
ĭ.Xs	1 YES 2 XNO	1 Inpetient 2 X		-	4 🗆 Nun	rsing Home		sidence (8 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF I (Month, Da	INJURY Iy, Year)	28b. TIMI	URY	28c, INJU WOR	PK?		28d. DESCRIBE HO	W INJURY OCC	CURED		
B≺	2 Accident investigation " 1 YES 2 NO												
								ute Number,					
	4 Homicide determined												
COMPLETED	29e. CERTIFIER 1 XCERTIFYING PHYSIC	HAN: To the best of	my knowledge, de	eath occum	ad at the f	time, date	and place,	and due f	to the cause(a) and i	manner ee staf	led.		
8	one) 2 MEDICAL EXAMINER	: On the basis of ex	amination and/or	investigatio	n, in my c	opinion, de	ath occur	ed at the t	time, data and place,	and due to th	ia cause(s)	and manner as stated.	
S I	296. SIGNATURE AND TITLE DE CERTUIER						2907 NICE					Month, Day, Year)	
∞ ∥	1					- 1			332	290. DAT		L7/95	
0 1	- V						-	- 10	2-3	1 '	7/1	.1173	

Fourth St., Oakland, MD

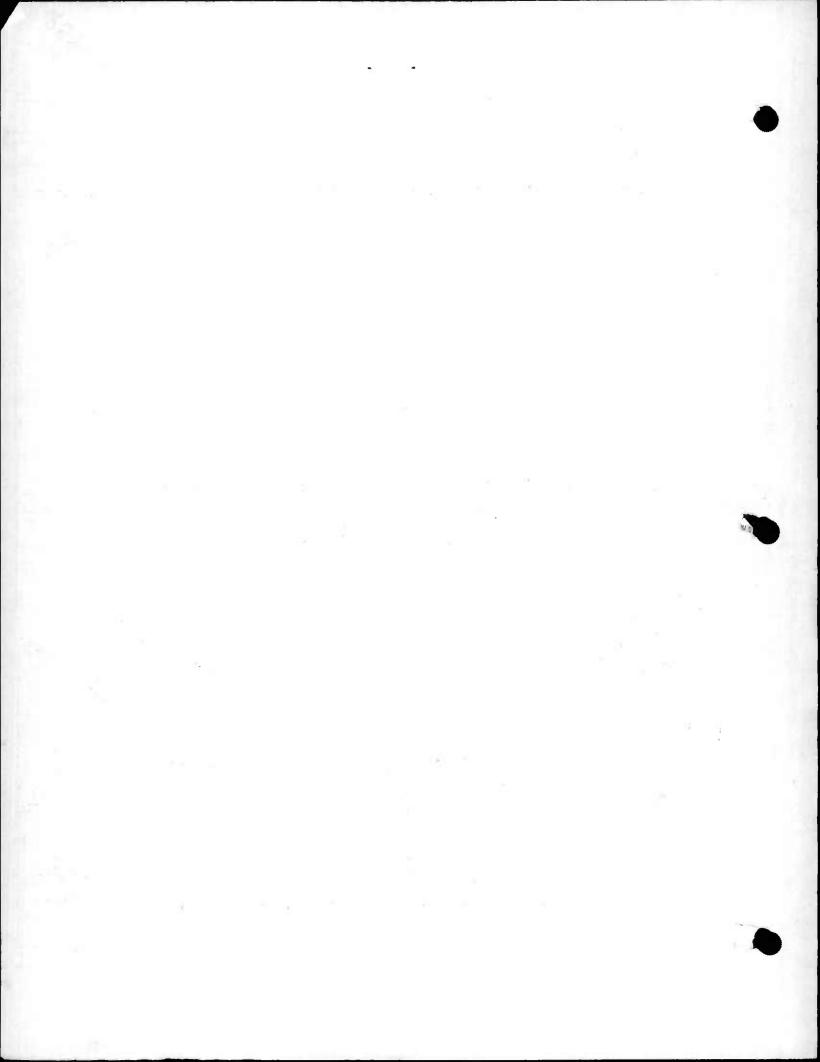
21550



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - FOR STATE REGISTRAR		STATE OF M.	ARYL	AND / D CEF	EPART	MENT OF	HEALTH	AND M	ENTAI	HYGIEN					
		1. DECEDENT'S NAME (First, Mic	ddle, Last)								2. DATE MONTH	OF DEATH	DAY	YEAR	3. TIME OF DEATH	1	
		Tyrone 4. Social Security NUMBER		5. SEX		penci		E INCER 4 MEAN	T 4 m m m		Apı			995	0002	M	
			,	1. M 2 F				ONTHS DAYS	HOURS	R 24 HRS.	7. DATE (Month	Dey, Year)		8. BIRTHP Country	PLACE (State or Fore	ign	
pino		218-02-074(X	28						une	25.	-		1and		
ending physician. as the burial-transit permit. Pages 1, 2, 3 should	OR	90. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Cntr. Cheverly RESIDENCE OF DECEDENT Prince Georges													9		
1.	ည္မ		b. COUNTY	-	_			TOWN OR LOCA	TION								
nit. Pag	DIRECTOR		rino	ce Georg	ge			r Mar		0					10d. INSIDE CITY LIMITS? 1 YES 2 N	Ю	
isit pen	FUNERAL	9404 Croom	Roa	d				10	2 0 7	772			1		AT COUNTRY?		
ician. Il-trar	2	11. MARITAL STATUS		12. WAS DECEDENT	EVER II	N U.S. ARMEI	D	13. WAS DE	CENDENT	OF HISPANIC	OBIGIN	? (Specify Ve		.S.A	- American Indian		
or attending physician r use as the burial-trar	BY FI	1 Never Married 2 Mer 3 Widowed 4 Divorced		FORCES? 1 [IF YES, GIVE WA	YES	2 _√ NO		If yes, s	pecify Cub 3 2 M NO	en, Mexican,	Puerto F	ican, etc.)	a or No	Black, Specify	White, etc.		
as as		15, DECEDE	NT'S EDUC	ATION		184 DECEC	NENT'S III	BUAL OCCUPATI	ION!		401	VIII. 05 01		Maria.	Black		
or at		(Specify only hig	hest grade	completed)		(Give I	dnd of wor	k done during m	ost of worki	ing	165.	KIND OF BU	ISINESS/IND	JSTRY			
ed fo	2	Elementery/Secondary (0-12)		College (1-4 or 5+)				Labo			l _C x		0	1			
by the hospital or att be detached for use at once.	COMPLETED	17. FATHER'S NAME (First, Middle	, Last)			DKI.	TIEC	цаво		NER'S NAME			Con	diti	on	_	
2 Pe d	Ш	Leon E.	S	pencer					Hel		. (r mat, m	ruuis, maider		D			
5 should notified	00	19e. INFORMANT'S NAME (Type/		peneer	-	19b. M	AILING A	DDRESS (Street			de Numb	er City or Tru	ve State Zin	Dors	зеу	_	
5 st	2	Sherree Spe	ence	r											770		
may be or, page ist be		20a. METHOD OF DISPOSITION			20b			DISPOSITION (N		уррег	DATE	Mar1boro MD 20772 DATE 20c. LOCATION — City or Town, State					
ector, pertor, p		1 ☑ Buriel 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		rval from State	Сел	armor	ory or othe	r place)		4/2	1/9		ndov	THE E			
Page al direc		21. SIGNATURE OF FUMERAL SE	ENVIOR DO	ENSER)	1	<u> </u>	<u>, , , , , , , , , , , , , , , , , , , </u>		ND ADDRE	ESS OF FACIL		у ца	nuovi	SI I	ID		
ter death. Page 6 may be the funeral director, page account of the funeral director, page account to the page of t		Hours	D	Calle	/			Adam	s Fi	mera	1 H	OMA	A a 11 2 6		MD 206	ΩΩ	
pura after or ramos medical		Adams Funeral Home, Aquasco MD 20 23 PART I. Enter the draeses, or complications that coused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately the province of the course of th															
δE	- 1	IMMEDIATE CAUSE (Final	ranure. L	list only one caus	on e	ech line.		1	1	1)	-			Onset and I		
ompletely in i, cremation, event, the		disease or condition resulting in death)		24	01	b IA	R	nals	to	o Ch	se,	14	-				
completely ial, cremati event, t		tooding in death)	•	DUE TO (C	R AS A	CONSEQUE	NCE OF):								+		
	Z	Commendate No.															
e be execute sician and conion to burial	CERTIFICATION	Sequentially list conditions if any, leading to immediate	0	DUE TO (C	R AS A	CONSEQUE	NCE OF):										
cate be hysician prior	S	cause. Enter UNDERLYING CAUSE (Disease or Injury	4 c														
n certificate nding phys Hygiene p or other	E	that initiated events resulting in death) LAST		DUE TO (C	R AS A	CONSEQUE	NCE OF):										
= e = -	H	rosaling in death) EAST	d														
that the death led by the attenth th and Mental any Injury, o		PART II. Other algnificant of	onditions	contributing to d	eath b	ut not resu	ilting in	the underlyin	g cause	given in Pa	rt I.	24a, WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINE	MMGS	
that the bod by and h and link	ICAL									TALL DESCRIPTION OF SEC.		PERFO		1	WAILABLE PRIOR TO)	
requires seen signa of Healt	MEDI										-	YES :	Z NO	(OF DEATH?		
	2 ≥	DID TOBACCO USE	CONTR	IBUTE TO CAU	SE O	E DEATH	YES	Пиог	1 LING	CERTAIN					YES 2 - NO	,	
has the Dept	PHYSICIAN:	25. WAS CASE REFERRED TO ME				_		(Check only one)		LKIAIIA	<u> </u>						
NN: The ficate h State	SIC	EXAMINER? X YES 2 NO		HOSPITAL:	R/Outp	etlent 3 🗆		THER:	ne 5 □ B	neidence 8	Other	(Specific)					
SICIA certif h the	并	27. MANNER OF DEATN		28e. DATE OF IN			Bb. TIME C	OF 28c. IN.	JURY AT	-			INJURY QCCI	JRED,) A		
ATTENDING PHYSICIAN: The law ECTOR: After this certificate has be after death with the State Dept 28 is marked, or frem 23	ВУР	1 Netural 5 Pend 2 Accident trives	ding stigation	(Mohth, Day,	193	5 2	Z/O	M 1	YES 2	1	50	bin	eed.	5/20	bb eel		
Apring : After death	0 8	3 Suicide 8 Coul		28e. PLACE OF	NJURY	- At home,	form, stre	et, factory, offic	. /	2	8f. LOCA	TION (Street	end Number o	r Rural Ro	ute Number,		
OR ATTENDING DIRECTOR: After hours after death	里		rmined	building, et	c. (Spec	57	PE	27			143	D State	Odiex	~ RH	2 524	1	
DIRIC DIRIC	COMPLETE	29e. CERTIFIER 1 CERTIFYII	NG PHYSIC	IAN: To the best of m	y knowl	ledge, death	OCCUPINA!	of the time date	and also	and thus to		- / 10			, = 00		
	M	one) 2 X MEDICAL	EXAMINER	: On the basis of exam	mination	n end/or Inve	ntigation.	in my opinion.	leath occu	red at the time	ne date	end place or	rivier ee state	Causala'	and mannes se care	and .	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If		29b, SUNATURE AND TITLE OF	_				^	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				piece, ei				FG.	
표본을	BE	10 1	4	- Inl	/	111)		Z9c. LIC	ENSE NUMBE	ER		29d. DATE	SIGNED (Wonth, Day, Year)		
668₹	2	30 NAME AND ADMINISTRATION	BSON WAY	COMPLETED COMP	25.05	-/VV	/		0	C.M.	F		A	oril	15 19	95	

111 Penn Street, Baltimore, Maryland 21201



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

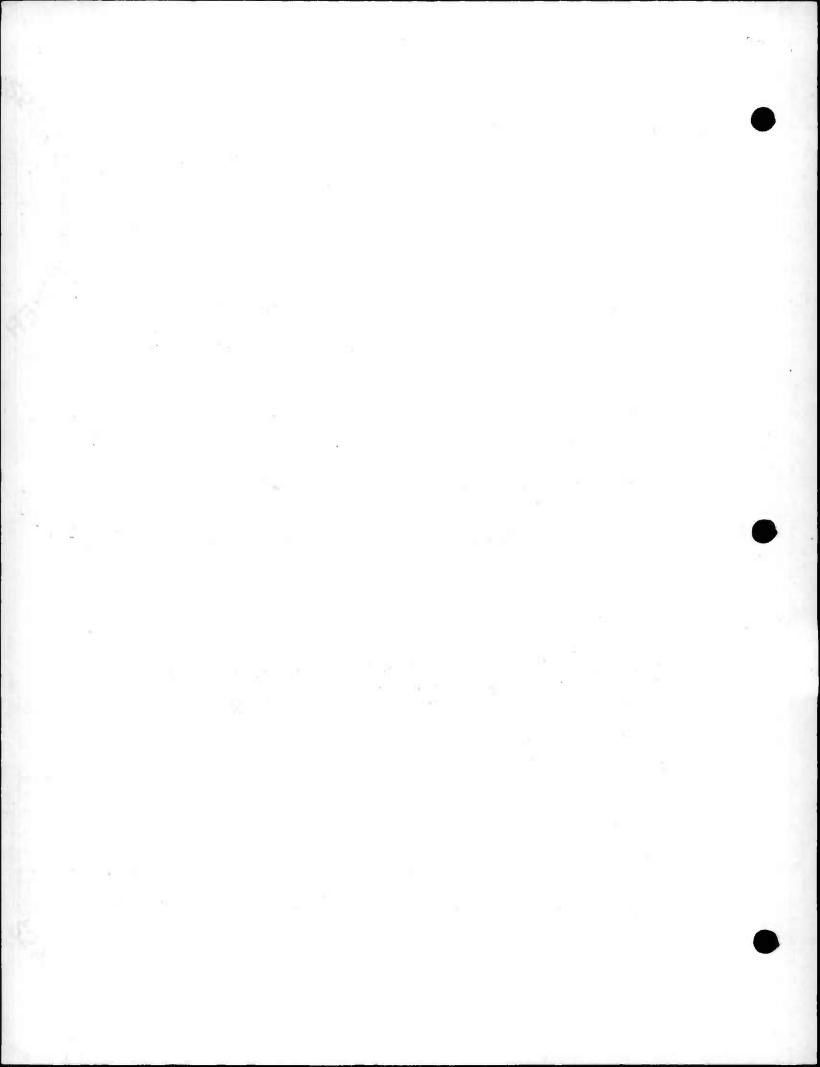
tySiCIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	ician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should	ith the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal.	traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: froms after death. Page 6 may	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH MONTH DA	Y	YEAR	3. TIME OF DEATH
		Υ_		Ir		Anril 21		205	9.)()(n M				
	4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yr	s. lest birthday)	IF UNDE	DAYS	_	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI	IPLACE (State or Foreign
		215-14-1705 TX M 2 🗆 F					DAYS	HOURS	MITTE.	NOV. 8, 1	915		YLAND
اي	Se. FACILITY NAME (If not in	112				9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	EATH	9c. COU	NTY OF D	EATH
DIRECTOR	FREDERICK M		L HOSPIT	AL		FRE	EDER	RICK			FF	EDER	ICK
E E	10a. STATE	10b. COUNTY			10c. Ci	TY, TOWN	OR LOC	ATION					10d. INSIDE CITY
듬니	MARYLAND	CARR	OLT			IDDLE							LIMITS?
占	10e. STREET AND NUMBER			_				10f. ZIP CODI	E		10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	6240 MIDDLE	BURG R	OAD					2	1757	,		US	А
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S	S. ARMED	13.				HC ORIGIN? (Specify Yea	or No-	-	E — American Indian, k, White, atc.
BY	1 Never Married 2 2 3 Divo		FORCES? 1 IF YES, GIVE V	WAR OR DATES	K NO			epecify Cube		n, Puarto Rican, etc.)			CASIAN
	15. DEC	EDENT'S EDU	CATION	18/	. DECEDENT	S HALLSH C	OCCUPAT	TION		18b. KIND OF BUS	INCO (IN		CASIAN
	(Specify only Elamentary/Secondary (0	y highest grade	completed) Callege (1-4 or 5		(Give kind of life, Do NOT	work done	during r	most of working	ng	160. KIND OF BOS	INE35/IN	DUSTRY	
4	1.1th	7-12)	Conege (1-4 or 5		PARTS N	MANAC	FR			FARM EQ	TITPM	ENT	SALES
COMPL	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTI	HER'S NA	ME (First, Middle, Malden			DI ILLED
BEC	NEWTON	ELMER	SIX,	SR.				BER	THA	MAE	CO	LLIF	LOWER
0	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILIN	G ADDRES	S (Stree	t and Number	or Rural i	Route Number, City or Town			
=	RETA M. SIX				6240	MIDE	LEB	URG R	OAD	MIDDLEBUR	G, M	ARYL	AND 21757
	20a. METHOD OF DISPOSITI	ION on 3 🗆 Reme	oval from Stata		ACE AND DATE						CATION -	City or To	own, State
	4 Donation 5 Other			MIC	DLEBUI	_			_		DLEBURG, MARYLAND		
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSINE	0		22.	. NAME	AND ADDRE	SS OF FA		T BA	тлтм	ORE STREET
	1.	Clus	Kud	u		S	KIL	ES FU	NERA	L HOME TAN			
RTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
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DICAL	PART II. Other significe		ne contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WIS AN AUTOPSY PERIPHENAL VASC DISCARGORMED? 24f								. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
	Colon	tha	ARTE	u l	JIZPI	ASE					J		OF DEATH? 1 YES 2 NO
ž	DID TOBACC		CONTRIBUT				HTA	YES	1 NC				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?						26.	PLACE OF D	EATH (Ch				
הַ	1 TES 2 NO		HOSPITAL:	ER/Outpaties	nt 3 🗆 DOA	4 Nu		ome 5 🗆 Re	sidenca	8 Other (Specify)			
67 PH	43	Pending Investigation	28a. DATE OF (Month, D		28b. Til	ME OF JURY M	٧	NJURY AT VORK? YES 2] NO	28d. DEŞCRIBE HOW II	NJURY OC	CURED	
200 PLACE OF IN HIPV At home from effect feeting office.								Route Number,					
COMPLETED										to the cause(s) end man			a) and manner ae stated.
O BE	29b. SIGNATURE AND TITLE	۵.	Kfin	~	Min			29c. LICE	21	HH	29d, DAT	E SIGNED	(Month, Day, Year)
	30. NAME AND ADDRESS OF	GR1	mol	1471	AT 7	e, Print)	1	AVE	Su	TE 204	FR	676	null mb
		4 1995	32. REGISTRA										



YEAR

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3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

APRIL

FOR STATE REGISTRAR

PETER

1. DECEDENT'S NAME (First, Middle, Last)

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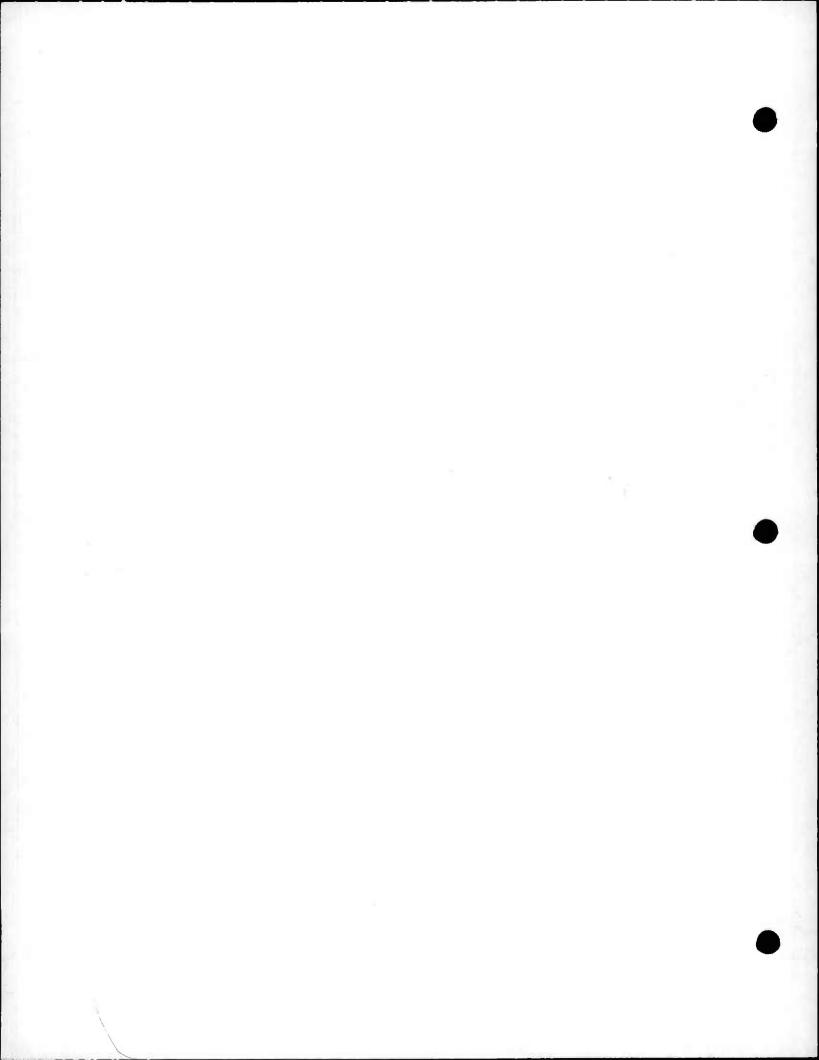
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8:30 A.M.M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
AUG. 13, 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 579-38-6517 DAYS 1 K M 2 - F 89 SOUTH DAKOTA 1905 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5714 WILSON LANE BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY **BETHESDA** 1 TES 2 NO hours after death. Page 6 may be retained by the hospital or attending physician. at in by the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e STREET AND MIMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5714 WILSON LANE 20817 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxican, Puerto Rican, stc.) 11. MARITAL STATUS 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Married 1 TES 2 NO Specify: WHITE В Specify: 3 🔀 Widowed 4 🗋 Divorced COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of the Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ATTORNEY LAW once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SOLEM ਲ HENRY MARY VOGLAND BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 SHERLEE S. NELSON BETHESDA METRO CENTER, BETHESDA, MD. 20814 pe METHOD OF DISPOSITION 20a. METHOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must FT. LINCOLN CEM. ☐ Donation 6 ☐ Other (Specify) 4/18 BRENTWOOD, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE. non WASHINGTON, D.C. 20016 filled in by the fillion, or removal. money medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between cremation, or IMMEDIATE CAUSE (Finel Onset and Death other traumatic event, the disease or condition Muli infract
OUE TO (OR AS A CONSEQUENCE OF): completely demention resulting in death) executed with physician and comp DOE TO JOY AS A CONSEQUENCE OF: CERTIFICATION Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING 8 signed by the attending physician Health and Mental Hygiene prior death certificate CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in desth) LAST 0 injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. the the MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? requires that shows any 1 - YES 2- NO OF DEATH? 1 YES 2 NO peen 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 12 UNCERTAIN 1 PHYSICIAN: Dept. AMP. 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The certificate h item HOSPITAL: OTHER: 1 TES 2 NO OR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28c. INJURY AT WORK? this c 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO After t BY 2 Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, offica building, stc. (Specify) 69 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: after 4 🔲 Homicide 28 determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT; If Item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 4/14/95 -31 2 8112 30. NAME AND ADDRESS OF PERSON WHO COMPLETED PAUSE OF GEATH (IXEM 27) (Type, Print) 4530 CONNECTICUT AVE. N.W. WASHINGTON, D.C. DR. DAVID V. YOUNG 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE who davelson Revolate 18 1995 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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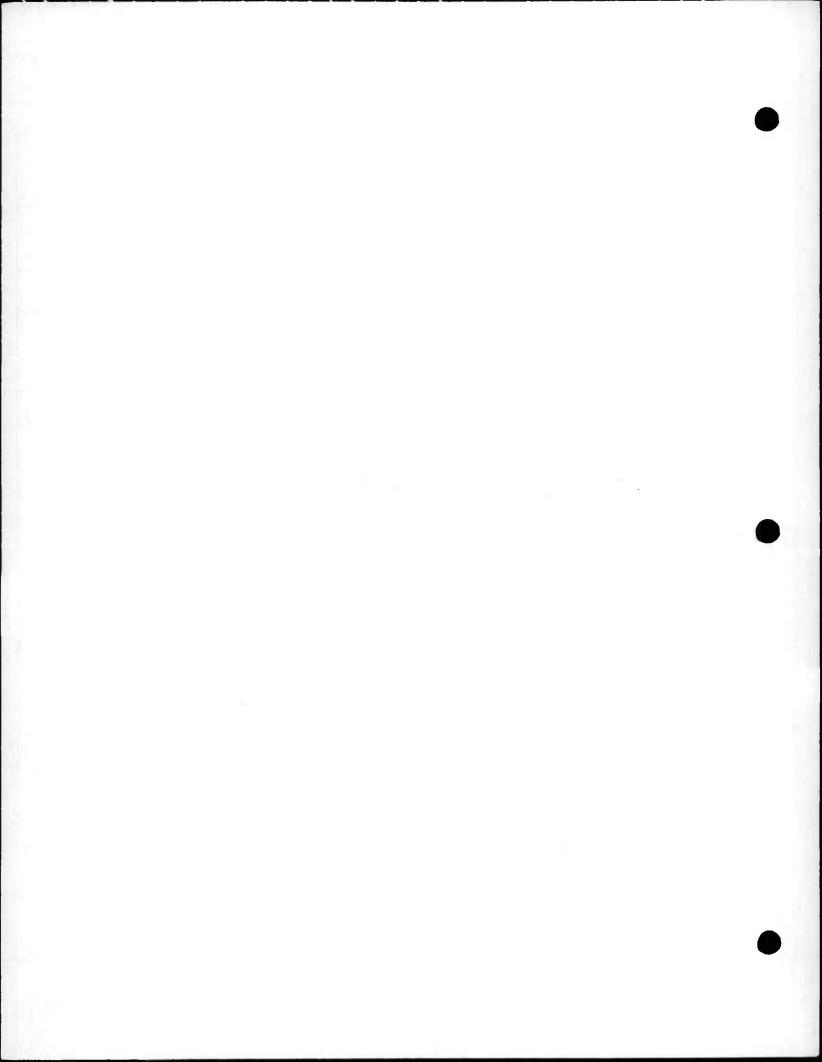
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Anna M. Smith 1995 12, April 2:30 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign 1894 578-52-2026 1 🗌 M 2 💢 F 101 January 26 New York Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Sacred Heart Home Hvattsville Prince George's RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Hyattsville n by the funeral director, page 5 should be detached for use as the burial-transit permit, removal, 1 T YES 2 | NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5805 Queens Chapel Road 20782 U.S.A. after death, Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, stc.)
 \(\subseteq \text{YE} \) NO Specify: 14. RACE — American Indian, Black, White, atc. 1 X Never Married 2 Married BY 3 Wildowed 4 Divorced White COMPLETED 16. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Accounting Clerk U.S. Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Charles W. Smith Mary T. Slaine BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JINDLE LELAND 322 WYNFORD DR. FAIRFAX, VA 22031 be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Stata must 3 | B 1 S Burlel 2 Cremetion 4 Donation 6 Other (Specify) Mount Olivet Cemetery Washington, D.C. examiner 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, 130 Wisconsin Avenue, N.W. washington, D.C. 20016 medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, filled in shock, or heart fellure. Liet only one cause on each line 6 Interval Between IMMEDIATE CAUSE (Finei Onset and Death cremation, or other traumatic event, the diseese or condition and completely for burial, cremation failure Chronic (ena resulting in death) 2 years DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leeding to immediate the attending physician Mental Hyglene prior to cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? and shows any Penile demention signed Health a 1 - YES 2 NO 1 YES 2 NO been t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DE UNCERTAIN PHYSICIAN: has b. Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item HOSPITAL: OTHER: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c marked. 28d, DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY After death Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28 is 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: 4 Nomicide item : 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If II MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) d 227 PC APRIL 12,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER M. SCHISSLER M.D. 7500 GREENWAY CENTER DRIVE # 430 GREENBELT, MD 20770 31. DATE FILED (Month, Day, Year)

Davidson Randall

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1995

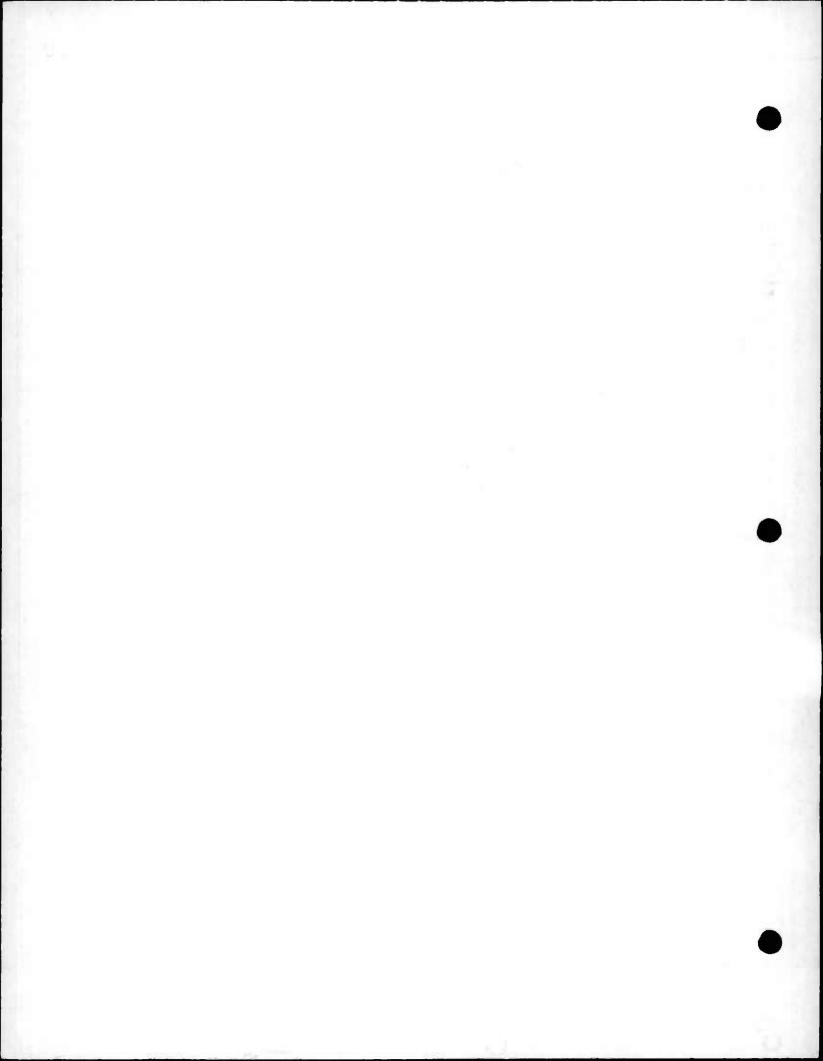


DHMH-16 Rev 1/89

FOR STATE REGISTRAR

1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH
MONTH DAY
1 - 7 - 1995 SHRAMCHEN KO 8.03 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) A. BIRTHPLACE (State or Foreign 579-44-3648 1 M 2 K F Russia January attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should intal Hygiene prior to burial, cremation, or removal. 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Montgomery Kensington 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3000 McComas Ave. 20895 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married B 3 Widowed 4 Divorced Specify: Spec#y.White COMPLETED 15. DECEOENT'S EOUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Home Homemaker 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at Peter Unknown Unknown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dimitri Lutchenkov 10805 McComas Ct. Kensington, Md. 20895 pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF OISPOSITION (Name of DATE 20c. LOCATION - City or Town, State HUST 1 N Burlel 2 Cremetion 3 Red 4 Donetion 5 D Other (Specify) Kock Creek Cemetery 4/10 Washington DC medicai examiner 22. NAME AND AGORESS OF FACILITY Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death event, the nemonia disease or condition resulting in death) Hous DIVISION OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, **OUE TO (OR AS A CONSEQUENCE OF** If any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 signed by the atter Health and Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO shows a OF OEATH? t TYES 2 NO has by Dept. PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h HOSPITAL: OTHER: 1 VES 2 NO Inpatient 2 DE ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending BY 1 YES 2 NO After death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. HOSPITAL FUNERAL within 72 ? = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(e) end menner es stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D43496 995 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20902 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE whi Daveler Randall 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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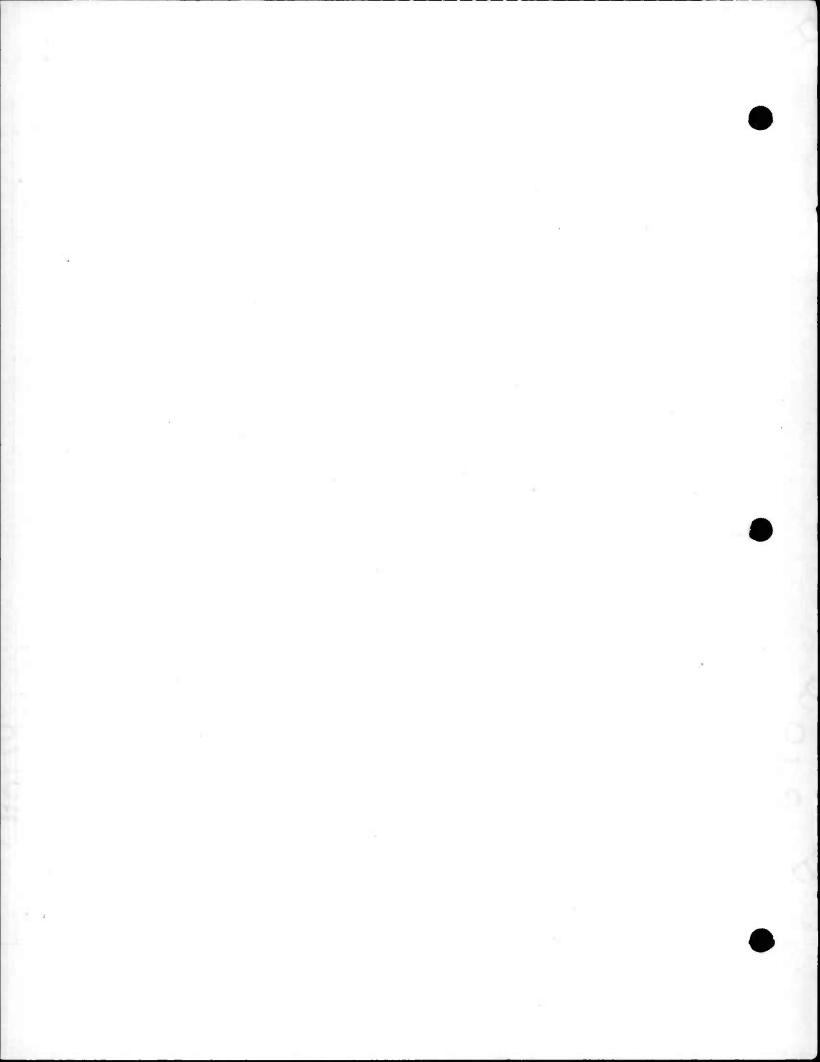
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within reforms after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

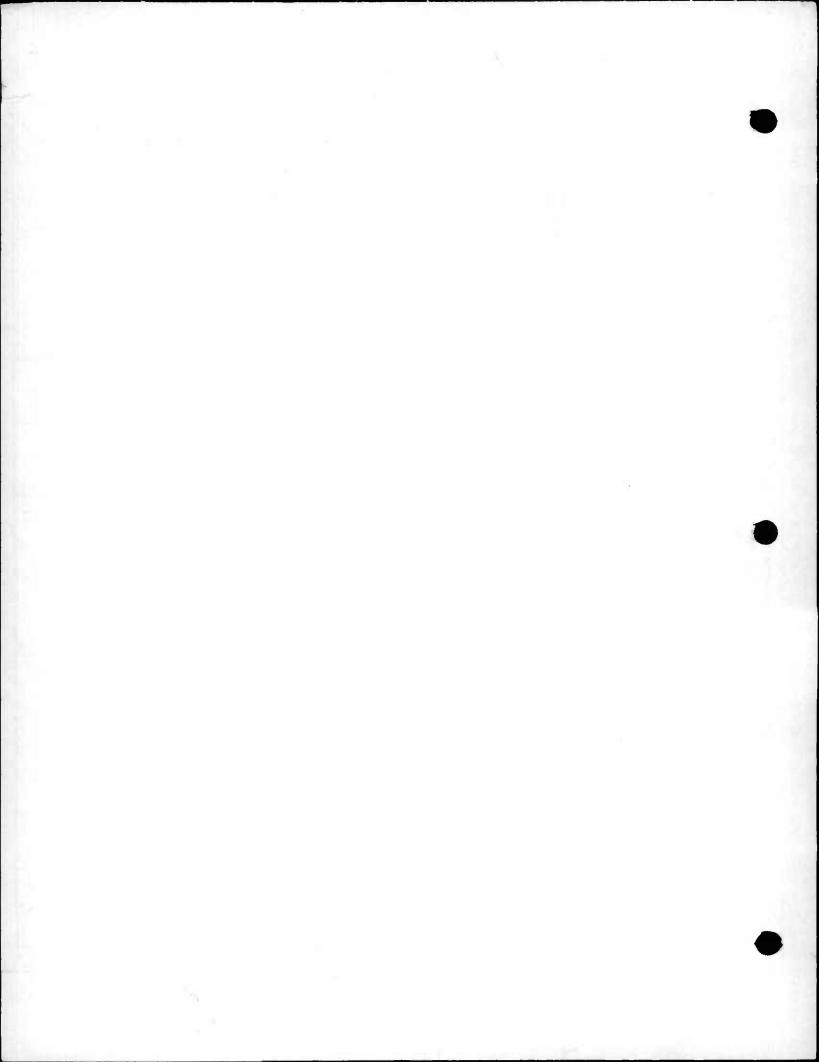
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

_								DEA		REG. NO.				
	1. DECEDENT'S NAME (First,	2200 000								2. DATE OF DEATH DA	W.	YEAR	3. TIME OF DEATH 8:05 A.M. M	
	John Deni		llivan							April 13,				
	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In y	yrs. last birthday)	IF UNDE	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign	
	077-14-4015		1 🔀 M 2 🗌 F	83	YRS.	WONTHS	DATS	HOURS	MATTER,	May 6, 19	11	New		
	9e. FACILITY NAME (If not in	stitution, give si	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	ATN	9c. COU	INTY OF DE	ATN	
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DIRECTOR	10e. STATE	10b. COUNTY	•		10c. CI	ry, town	OR LOCA	TION					10d. INSIDE CITY LIMITS?	
۵	Maryland	Mont	tgomery		R	ockv	ille						1 🔀 YES 2 🗌 NO	
× ×	10e. STREET AND NUMBER						10	f. ZIP COD	E		10g. CIT	IZEN OF WI	HAT COUNTRY?	
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בָּ	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.	S. ARMED	13.	WAS DE	CENDENT C	F HISPAN	IC ORIGIN? (Specify Yes	N? (Specify Yee or No. 14. RACE Ame			
BY	1 Never Merried 2 3 3 Widowed 4 Divo		IF YES, GIVE Y			If yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 ☐ YES 2 ☒ NO Specify:						Specify		
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Σ			4		011	icer				Mili	tary			
웅	17. FATNER'S NAME (First, M.	iddle, Last)						18. MOTI	NER'S NA	ME (First, Middle, Maiden	Surname)			
H H	Dennis Jose		llivan							rine Phale				
၉	190. INFORMANT'S NAME (7)	/pa/Print)			1					Route Number, City or Town				
٦	Mary Ann Mo								e Co	urt Olney,	Mar	yland	20832	
	20a, METHOD OF DISPOSITI	ON n 3 □ Remo	oval from State	20b. PL	ACE AND DATE	OF DISPO	SITION (N	ame of	21 .	1995 20c. LO	CATION —	City or Tow	n, State	
	4 Donetion 5 Other			Arl	ry, crematory or ington						ngton, Virginia			
	21. SIGNATURE OF TIMERAL	L SERVICE LIC	ENSEE	,		22. R <i>C</i>	NAME A	ND ADDRE	SS OF FAC	hrev Filner	al H	Iome/		
	Xlal	ana (1 1000	MOO	202	Ro	ckv:	ille,	Inc	hrey Funer 300 West le, Maryla	Mon	tgome	ery	
	23. PART I. Enter the di	seases, or c	omplications tha	t caused th	na death. Do	not antai	r tha mo	oda of dvi	ng. auci	Te, Maryla	ratory ar	10850-	Approximata	
	anock, or no	aart fallura. I	List only one cau	ise on aach	ı Ilna.			-					Interval Between	
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	resulting in death)		a DUE TO	(OR AS A CO	ONSEQUENCE (MED:	EPSIS						MORE THEN	
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<u>i</u>	CAUSE (Disease or Inju that initiated evants		DUE TO	(OR AS A CO	ONSEQUENCE O	ENCE OF):								
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	PART II. Other algolitica	nt condition	e contribution to	do ath hua		1- 44				-				
MEDICAL	TANT II. Other aignitice	CONDITIONS	s contributing to	death but	not resulting	in tha ui	nderiyin	g cause o	given in	Part i. 24s. WAS AN PERFOR		A	VERE AUTOPSY FINDINGS IVAILABLE PRIOR TO	
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ਤੇ	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF DEA	TN (Check								
Z	1 TES 2 NO		1 ₺ Inpatient 2 □	ER/Outpatie	nt 3 🗆 DOA			ne 5 □ Re	eldence	8 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATN 1	Decides	28e. DATE OF (Month, D		28b. Till IN	IE OF JURY	28c. INJ WC	URY AT		28d. DESCRIBE NOW IN	JURY OC	CURED		
à		Pending nvestigation				М		YES 2	NO					
	3 Suicide 8 0	Could not be	28e. PLACE O building.	etc. (Specify)	A1 home, 1erm,	atreel, lec	tory, offic	a		281. LOCATION (Street e. City or Town, State)	nd Number	or Rural Roo	ute Number,	
COMPLETED	4 Nomicide	ermined												
7	29e. CERTIFIER (Check only	IFYING PNYSIC	CIAN: To the best of	my knowledg	ge, death occur	ed at the t	lime, dete	end place,	end due	to the cause(e) end men	ner ee sta	ted.		
5										time, date end place, end			end menner se stated.	
	29b. SIGNATURE AND TITLE	OF CERTIFIER	. /					29c, LICE	NSE NUM	BER	29d, DAT	F SIGNED (A	Aonth, Day, Year)	
4	alalw I	Heloy	lu					DL	+24	26				
2	30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type	, Print)		- V	7		A	Бттт .	15, 1995	
	Mohammad Kh	alid,	M.D. 12	99 La	mberto	n Dr	ive	Silve	er Si	oring, Mary	vland	d 209	02	
			32 AEGISTRA	R'S SIGNATU	IRE.				- 51		, = 0.11			
	31. DATE FILED MORE DOWN	11995	32. AEGISTRA	anapor	Kardall]	



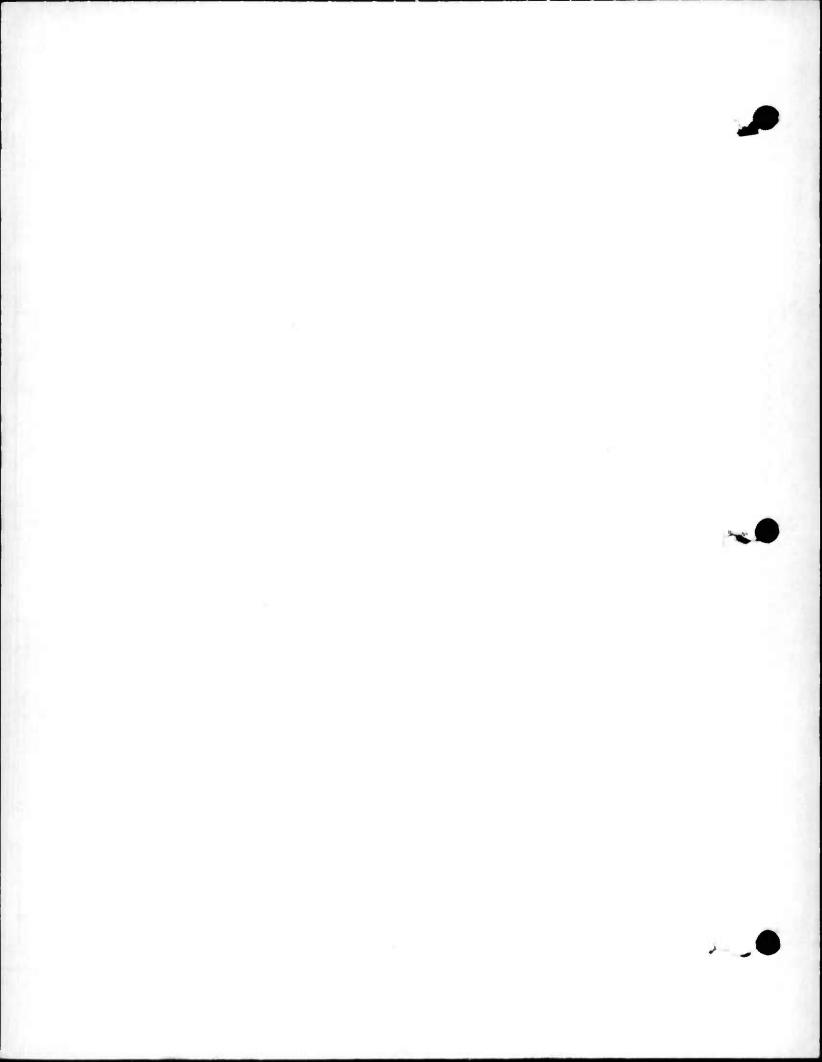
		Thended # 7 FOR THE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF MARYL	AND / DEPA	RT / RTMENT OF I	Monte HEALTH AND	MENTAL HYGIEN	C0 VE	5 J	3862	
		1. DECEDENT'S NAME (First, Middle, Last)	LANDERS		57	ONE	2. DATE OF DEATH		YEAR 2.1	TIME OF DEATH 45 P	
Pin		4. SOCIAL SECURITY NUMBER 037-32-9136	1 □ M 2 🗓 F 48	In yrs. lest birthday, YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH SEPT. 29,	1948	Country)	CE (State or Foreign	
1, 2, 3 should	ECTOR	99. FACILITY NAME (If not institution, give s SUBURBAN HOSPITA) RESIDENCE OF DECEDENT			BETHES	DA	DEATH		GOMER		
permit. Pages	DIR		GOMERY		TY, TOWH OR LOCA EVY CHAS					LINSIDE CITY LIMITS? YES 2 1 NO	
usit	NERAL	3107 CUMMINGS LAI				20817		U.S.	A.	COUNTRY?	
21215-0020 all or attending physician. for use as the burial-transit	BY FUNE	11. MARITAL STATUS The Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 ZNO	If yes, s	CENDENT OF HISPA pecity Cuben, Mexic S 2 ⁴ NO Speci	NIC ORIGIN? (Specify Yeen, Puerto Ricen, atc.)	s or No— 1	Specify:		
21 al or for u	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1.2	College (1-4 or 5+)	(Give kind of life, Do NOT	s USUAL OCCUPATION Work done during muse retired.) CARETAKE	ost of working	U.S. GO		STRY		
MARYLAND 2- retained by the hospital o 5 should be detached for notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) HOWARD LYONS ST	TONE, JR			16. MOTHER'S N.	AME (First, Middle, Maiden				
	TO B	190. INFORMANT'S NAME (Type/Print) OLGA STONE		196. MAILIN 3107	G ADDRESS (Street CUMMINGS	and Number or Rural	Floute Number, City or Tow EVY CHASE,	MD • 2	0815		
ALTIMORE death. Page 6 may e funeral director, pa al.		20a METHOO OF DISPOSITION 1 M Burlel 2 Cremation 3 Rem 4 Donation 5 Qther (Specify) 21. SIGNATURE OF FUNEBAL SERVICE US	oval from State		JOSEP	AL CEM. ND ADORESS OF FA	4/21 ARL	INC.	VA.	20016	
within set hours aft pletely filled in by cremation, or remorement, the medical		23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused List only one ceuse on ee Presentations of the complex DUE TO (OR AS A	LA	not enter the mo	ode of dying, au	ch as cerdisc or resp	elratory arres	R,	Approximate Interval Batween Onset and Death Days	
P.O. BOX 68 sth certificate be executed tending physician and Hygiene prior to bur or other traumatifications.	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	b								
AL RECORD s law requires that the has been signed by the Dept. of Health and M	MEDICAL	PART II. Other aignificant condition DOWN FUND DID TOBACCO USE CONTI	NOTE BY OR NEW CAUSE OF	ocepha DEATH Y	in the underlyin		PERFOI	RMED?	COM OF D	LABLE PRIOR TO PLETION DF CAUSE DEATH? YES 2 NO	
CIAN: Th	IYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Outpa	itient 3 🗆 DOA	OTHER:		6 Other (Specify)				
ONG DING After death	ED BY PHY	1 Netural 5 Pending Investigation 3 Suicide 6 Could not be	26e. DATE OF INJURY (Month, Day, Year) 26e. PLACE OF INJURY - building, etc. (Specif	— At home, term,	JURY WO	JURY AT DRK? YES 2 NO	28t. LOCATION (Street City or Town, State)	end Number or		Number,	
로 기자 =	COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowle	edge, death occur	red at the time, date	end place, end due	to the ceuse(e) end ma	nner se stated.			
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: II	H	296 SIGNATURE AND TITLE OF TERTIFIER	R: On the basis of examination)	on, in my opinion, c	29c. LICENSE NU				th, Day, Year)	
/	5	1525 Shady Qu	COMPLETED CAUSE OF DEA	TH (ITEM 87) (TYPE	le Hol	20850	ALAN	5- 0	HAN	ACEP MA	
		APR 18 1995	32. REGISTRAR'S SIGNA	TURE O Ardall						-	



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BALTI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, P.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complex y filled in by the funeral
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR	DIR
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31. DATE FILED (Month, Day, Year) APR 21 1995

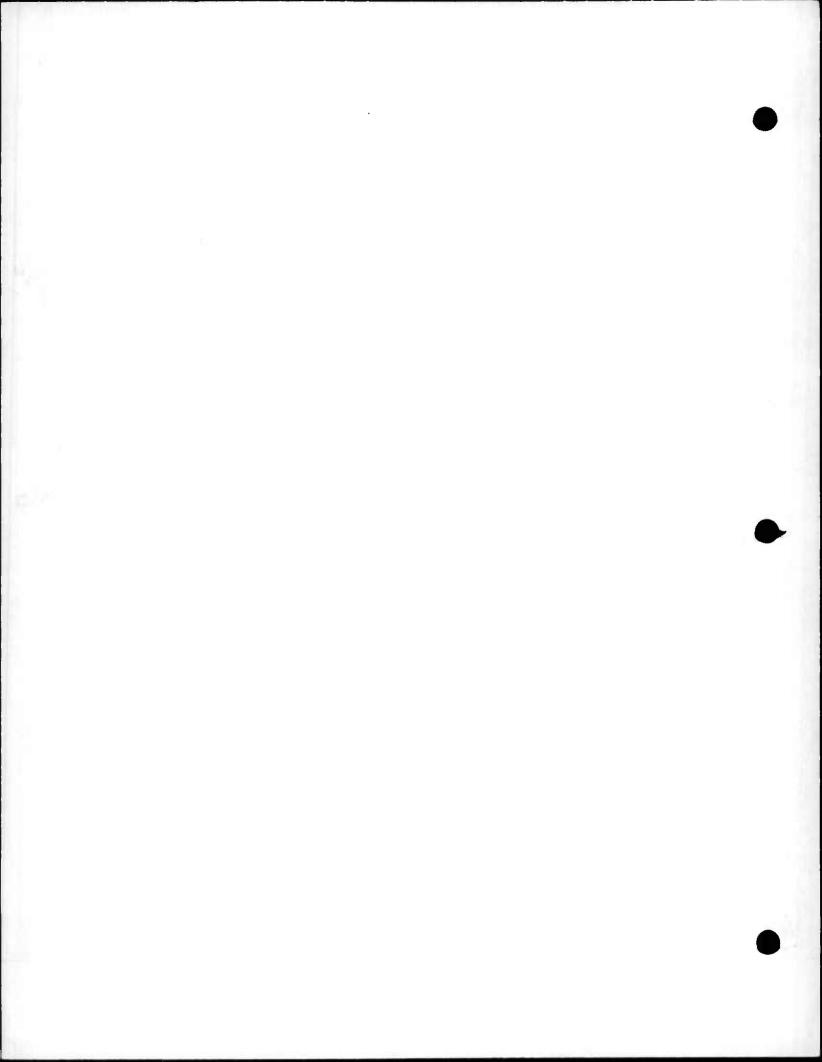
	1 - STATE REGISTRAR		STATE OF I	MAKYLAN				F DEATH		NTAL HYGIEN REG. NO.	_		
	1. DECEDENT'S NAME (First, A	Middle, Last)							2.	DATE OF DEATH		3.	TIME OF DEATH
	Shawki		Shiblie					1		MONTH BA	9	YEAR 3.	9:30 A M
	4. SOCIAL SECURITY NUMBER		5. SEX		yrs. last birthday) 58 YRS.	IF UNDE	ER 1 YEAR		MIN.	DATE OF BIRTH (Month, Day, Year)			ACE (State or Foreign
	242-50-8506 9e. FACILITY NAME (If not insti				OO YRS.				Ju	11y 18, 1		Pales	
<u>e</u>	Holy Cross							N OR LOCATION				Y OF DEAT	
CTOR	RESIDENCE OF DECE	DOSAT	taı			Этт	rver	Spring	3		Mont	gomer	<u>'y</u>
DIRE		10b. COUNTY			10c. CI1	ry, town	OR LO	CATION				10	d. INSIDE CITY LIMITS?
0	Maryland 1	Montg	omery		W.	Theat	-						YES 2 NO
VERAL	11505 Taber	Stree	t					20902				USA	T COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 M M 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	1 YES	2 NO	13.	If yes,	DECENDENT OF H specify Cuben, N ES 2 X NO	Maxican, Pu	RIGIN? (Specify Yes serto Rican, stc.)		Specify:	American Indian, hite, atc.
1 1 1 1	15. DECED (Specify only h	DENT'S EDU	CATION completed)	16	6a. DECEDENT'S	USUAL C	OCCUPA	TION most of working		16b. KIND OF BUS			ter allo a a allo tot
once.	Elementary/Secondary (0-12		College (1-4 or 5 e	+)				most of working		5	7 1	3.	
once.	12 17. FATHER'S NAME (First, Midde	ida (ast)			Deli	CI	lerk			Retail		Stor	e
20 111	Shiblie Shi								leh S	First, Middle, Meiden	Surname)		
2 0	19a. INFORMANT'S NAME (Type				19b. MAILING	ADDRES	SS (Stree			Number, City or Town	n. State, Zip C	Code)	
	Victor Shib	lie								ton, Mar)2
must be	20e. METHOO OF DISPOSITION 1 M Burlet 2 ☐ Cremetion	3 🗆 Rame	oval from State	20b.PL cemete	ACE AND OATE	OF DISPO	SITION	(Neme of	1		CATION — CH		
	4 Donation 5 Other (S		acrost .	Gat	e of H			emetery		/21 Silv	er Sp	ring,	Maryland
amin	21. SIGNATURE OF FOREIGNE	/ /	I +	- 4	1000.	22	NAME 1180	O New 1	OF FACILITY Hamds	Hines-Ri hire Ave	naldi	Fune	ral Home
or removal. medical examiner	23. PART I. Enter the dise	0	Deru	7/1	KKAN	S	šilv	er Spri	ing,	Maryland	l 209		
g #	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially liet condition if any, leading to immedia	ene,	a. Cara	O OR AS A CO	ONSEQUENCE O	th.	\)\S+	are.					Approximata interval Batween Onset and Daath
	cause. Enter UNDERLYING CAUSE (Dissesse Dr injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.												
shows an	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO											MILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
8 8 P	25. WAS CASE REFERRED TO I		(IBUTE TO CA		PLACE OF DEA				TAIN L]			
	EXAMINER?		HOSPITAL:			OTHE	R:	ome 5 🗆 Raside		Other (County)			
을 하 🗲	27. MANNER OF DEATH		26a. DATE OF (Month, De	NJURY	28b. TIM	_	28c. II	NJURY AT		DESCRIBE HOW IN	JURY OCCU	RED	
s marked,	1 Netural 5 Pe	ending vestigation				М	1 🗆	WORK? YES 2 N	0				
m 28 I	4 Homicide det	ould not be itermined	28e. PLACE Of building	OF INJURY — (stc. (Specify)	At home, ferm,	street, fac	tory, off	fice	261.	LOCATION (Street a: City or Town, State)	nd Number or	Rural Route	Number,
2 = 5	one) 2 MEDICA		Toofine Dead of as							e cause(s) and mani			d manner as stated.
IMPORTANT: TO BE CO!	29b. SIGNATURE AND TITLE OF		1 W/W	L.		= 1 11	<i>A</i>	29c LICENSE	495		29d. DATE S	18/45	nth, Day, Year)
	10EC 60021	H M)	1470		UDOCPH		()	KOCK	cuill	c sno	ZOFS	L	
1	31. DATE FILED (Month, Day, Yea		32. REGISTRA	ICK DON	all	1							



FOR STATE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 9:15A M 4. SOCIAL SECURITY NUMBER trost COF S SEY IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 031-14-7217 1 M 2 X F 69 YRS. March 19,1926 Maine the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR 5402 Huntington Parkway Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland ō Montgomery Bethesda 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5402 Huntington Parkway 20814 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried BY 1 YES 2 NO Specify: 3 📉 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY College (1-4 or 8 +) Elementary/Secondary (0-12) Nursery School Teacher Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Ernest Willard Frost Ethel Semple BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert E. 5402 Huntington Parkway, Bethesda, MD 20814 Sylvester pe 20a, METHOD OF DISPOSITION
1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACEAND OATE OF DISPOSITION (Name of cometary, crematory or other place) April 24,1995 Puritan Lawn Memorial Park DATE 20c. LOCATION - City or Town, State must □ Donation 5 □ Other (Specify) Peabody, Massachusetts examiner 21. SUMATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Funeral Inc. M00348 7557 Wisconsin Ave., Bethesda, MD 20814 medicai filled in by 1 23. PART I. Enter the diseases, or complications/that caused tha deeth. Do not enter the mode of dying, auch as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line 0 Interval Between **IMMEDIATE CAUSE (Final** Onset and Death event, the disease or condition resulting in death) and completely fi to burial, cremation anteriosclapote executed within DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION other traumatic Sequentielly list conditions, signed by the attending physician at Health and Mental Hygiene prior to DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST 10 PART ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 TYES 2 X NO 1 TYES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State certificate I HOSPITAL: OTHER: YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27, MANNER QE BEATH 26a. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT this c 26d. DESCRIBE HOW INJURY OCCURED Netural 1 YES 2 NO ВУ After death 2 Accident hours after de item 28 is s 3 Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) COMPLETED 6 Could not be DIRECTOR: 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT; If Item 2 29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated.

MEGICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIF BE 29c. LICENSE NUMBER 29d. OATE SIONEO (Month, Day, Year) 186Q 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AG 8218 WIS GUS (N) Auc Fee The sol 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 21 1995 This Davelson Reveall



FOR

ORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

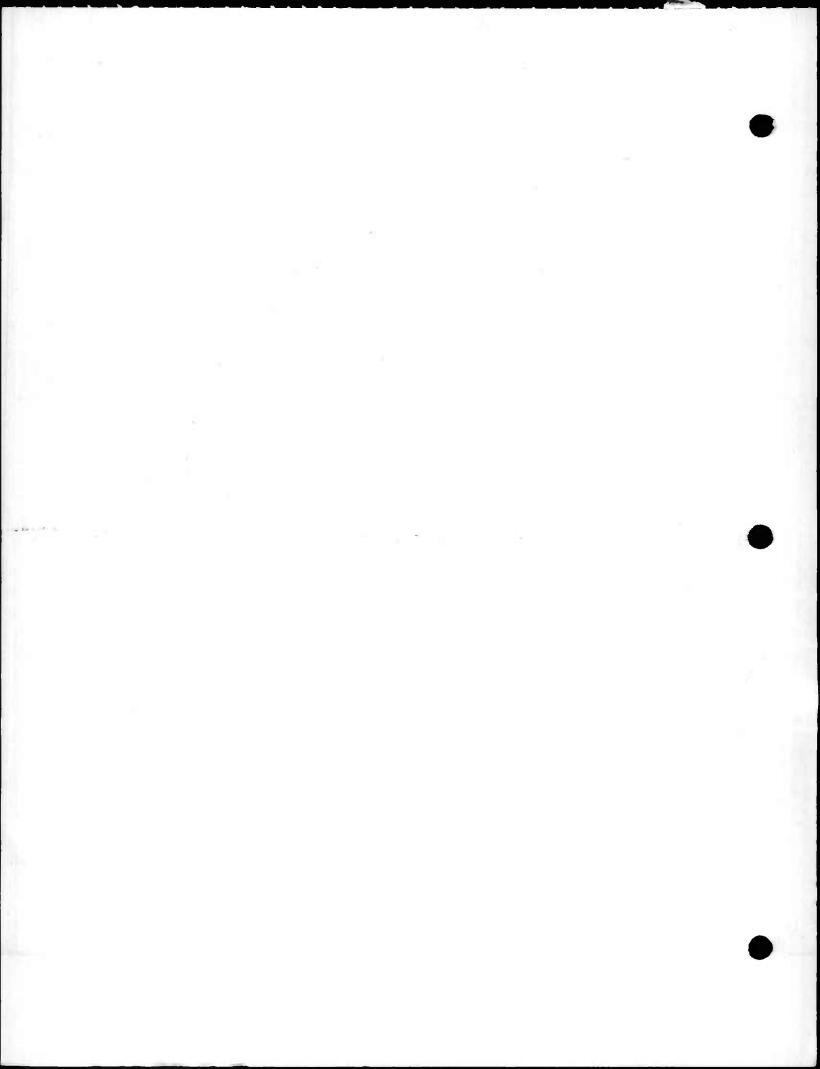
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - REGISTRAR				CE	RTIF	CATE	OF	DEATH	101214	R	EG. NO				
											EATH	AY	YEAR	3. TIME OF D	EATH
		F0												2:30	А. м
		1 M 2 X F			birthday)			IF UNDER 24 HRS. HOURS MIN.	Jü	TE OF B	13 T ^{er)} 1	914	Count	Y)	Foreign
									DEATH						-
MD	Mont							_						LIMITS?	
Secretary and professional prof		101. ZIP CODE 10g. CITIZEN OF WHAT COUNT											7		
1 Never Married 2		FORCES? 1	YES	2 XN	MED O	If y	es, sp	ecify Cuban, Maxi-	can, Puar	GIN? (Sp to Rican	ecify Yes	or No-	Black	t, White, atc.	
										16b. KINI	OF BU	SINESS/IN	DUSTRY		
	-)	life.	Do NOT us	e retired.)		or or working			3ove	rnme	nt		
												Surname)		_	
								<u> </u>							
														J 55426	;
		and dates State		PLACEA	NDDATEC	F DISPOSITION			_						_
1 XBurlei 2 Cremetion 3 Removal from State Cemetery, cremetory or other place) 4 Donation 5 Other (Specify) Mt Lebanon 4-23 Adelphi MD															
21, SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE				Edw	arc	d Sagel	Fun						
23. PART 1. Enter the diseases, or correlications that caused the death. Do not enter the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as carried as a contract the mode of duling such as a contract the contract thas a contract the contract the contract the contract the contract															
iMMEDIATE CAUSE (Fir disease or condition	eart tanure.	a. PRIERI	e on e	(200	n	2001								interval Onset e	Between nd Death
If any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events	diate iNG iry	bDUE TO	(OR AS A	CONSEO	UENCE OF) :									
OSTED PORP	ondition	a contributing to	deeth b	ut not re	esulting i	n the unde	rlying	g cause given i	n Part i.		PERFOR	MED?	24b.	AVAILABLE PRIC COMPLETION O DF DEATH?	F CAUSE
DID TOBACCO U	SE CONT	RIBUTE TO CA	USE O	F DFAI	TH YE	S \square NO) [LINCEPTA	IN D					1 YES 2	J.NO
25. WAS CASE REFERRED TO								OTTERIA							
1 TES 2 NO			ER/Outp	etlent 3	□ DOA		Hom	5 - Residence	8 🗆 0	ther (Spa	cify)			-	
1 Netural 5		28a. DATE OF (Month, Da	INJURY ly, Year)			JRY	WO	RK?	28d. [ESCRIB	E HOW I	NJURY OC	CURED		
3 Suicide 8	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rurat Route Number, Characteristics)														
(Check only														and manner of	
296 SIGNATURE AND TITLE	OF CERTIFIE	ionno	2					29c. LICENSE NI 468	UMBER			29d. DAT	E SIGNED	(Month, Day, Yea	
30. NAME AND ADDRESS OF	LL150	O COMPLETED CAUS	E OF DE	TH (ITEM	27) (NO9.	Print) M	550	CITUS CO	75 /3	ME,	N	مر د	18:	20016	
31. DATE FILED (Month, Day, APR 21	1995	Jalia Da	R'S SIGN	ROW	211										



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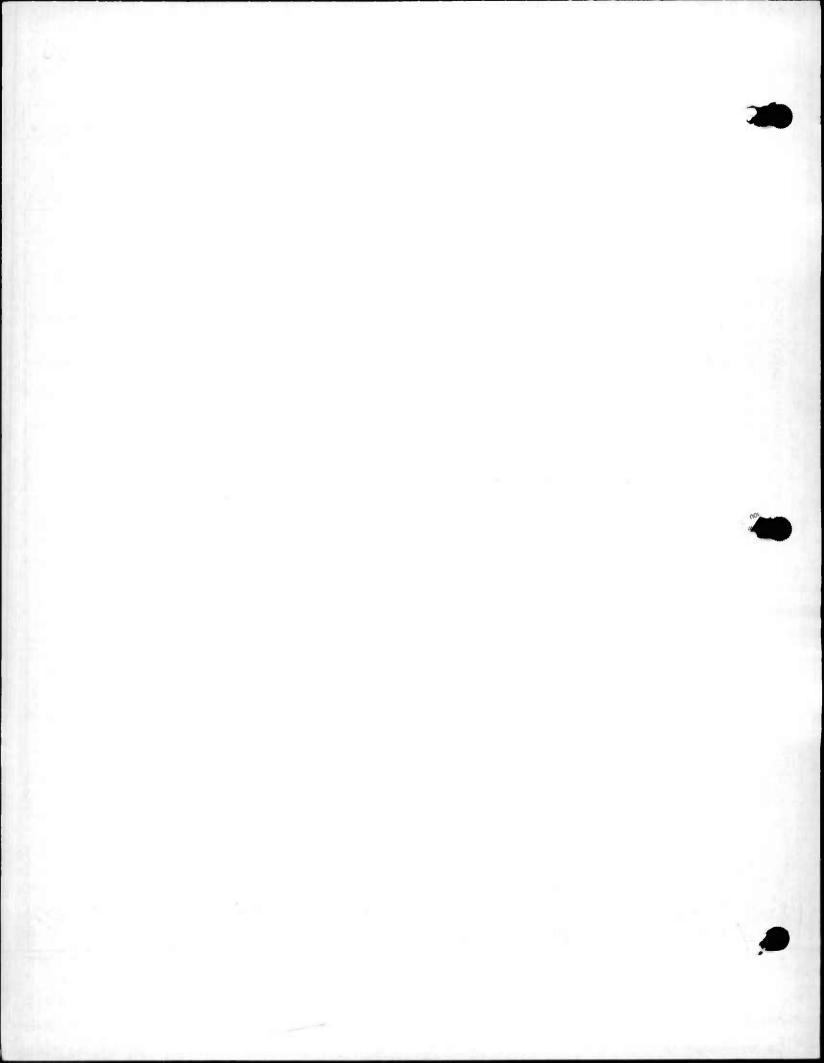
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	PITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
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urs after death. Page 6 may be retained by the hospital or attending physician.	Deposite of the contract of th	the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner

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	1 - STATE REGISTRAR		LAND / DEPAR CERTIF	RTMENT OF I	REALTH AND DEATH	MENTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	Dimo	SAR	1	/	2. DATE OF DEATH DO APRIL 13	95	
	4. SOCIAL SECURITY NUMBER 578-46-1801		E (In yrs. lest birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0	BIRTHPLACE (State or Foreign Country)
	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF D		907 B	SULGARTA OF DEATH
PD.	6808 TULIP HILL	<u> </u>		BETHESI	DA		MONTG	GOMERY
DIRECTOR	10a. STATE 10b. COUNT			Y, TOWN OR LOCATE THE SDA	TION			10d. INSIDE CITY LIMITS? 1 YES 2 P NO
	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	6808 TULIP HILL				20816		U.S.A	
BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexico 2 NO Specifi	NIC ORIGIN? (Specify Yea an, Puerto Ricarı, atc.) iy:		RACE — American Indian, Black, White, atc. Specify: WHITE
TED	15. DECEDENT'S EDU (Specify only highest grad		16a, DECEDENT'S	USUAL OCCUPATION Work done during more retired.)	ON ost of working	16b. KIND OF BUS	SINESS/INDUST	RY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	PRESID			PARKING	;	
w	17. FATHER'S NAME (First, Middle, Last) DIMO SARBOV				16. MOTHER'S NA UNKNOWN	AME (First, Middle, Maiden	Surneme)	
TO B	190. INFORMANT'S NAME (Type/Print) CHRISTINE S. SARE	30V	19b. MAILING 6808 T	ADDRESS (Street of ULIP HIL	nd Number or Rural	Route Number, City or Town	n, State, Zip Code	16
	20a. METHOD OF DISPOSITION 1	noval from State	0b. PLACE AND DATE of the order	OF DISPOSITION (Na ther place)			CATION — City	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	— COMPO	22. NAME AN	ND ADDRESS OF FA	NCILITY		
	* Kean	11/4/20	eso			R'S SONS, I		D-C 20016
	23. PART J. Enter the diseases, Dr shock, or heert fellure.	complications that cause on	ed the deeth. Do r	not enter the mo	de of dying, auc	ch as cardiec or reepi	ratory arrest,	Approximata Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	C	- 41		11-12			Onset and Death
	resulting in death)	a. GUNSHO	A CONSEQUENCE OF	DUND Fi	MEHP			ACUTE
N	Sequentially list conditions.	b. DEPRE	SSION	/				2 YVS
ATI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF	F):				
ERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):				
CERI	resulting in death) LAST	d						
	PART II. Other significent condition	na contributing to death	but not reaulting	in the underlying	g ceuse given in	Part I. 24s. WAS AN A		24b. WERE AUTOPSY FINDINGS
MEDICAL						1 YES 2	1/	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
						_		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF DEATH (Ch	eck only one)		
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	ipatient 3 DOA	OTHER:	A	6 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)		URY WO	RK?	28d. DESCRIBE HOW IN	JURY OCCURE	D
BY	2 Accident Investigation 3 Sculcide 6 Could not be	280. PLACE OF INJUR	95 063 TY - At home, larm, a	UN	ES 2 NO	SHOT IN	MEA	Jural Boute Number
ETED	4 Homicide determined	building, etc. (Sp	Hans			City or Town, State)	TO THOM OF THE	sen riodio riomon,
IPLE		ICIAN: To the best of my kno	wiedge, death occurre	ed at the time, date				
COMPL		ER: On the basis of exeminati	on end/or investigatio	n, in my opinion, de	eath occured at the	time, date end place, end	I due to the ceu	use(s) end manner ee stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIE	0/1	11	/X	29c. LICENSE NUI			ENED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CHUSE OF D	SEATH TITEM 271 / Type	Print	0070	79	BIRK	13 95

APR 18 1995

62. REGISTRAR'S SIGNATURE



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ON OF VITAL RECORDS, P.O. BOX 68	ENDING PHYSICIAN: The law requires that the death certificate be executed w
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SION OF VITAL RECORDS, P.O. BOX 68	ATTENDING PHYSICIAN: The law requires that the death
VITAL RECORDS, P.O. BOX 68	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

											9	5	386	7	
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR					MENTA	L HYGIEN				•	
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	E OF DEATH	IV.	YEAR	3. TIME OF DEAT	ГН	
	Roger Boyd Speck								April 21					:25	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. le	-	IF UNDE	ER 1 YEAR	IF UNDER :	24 HRS.		OF BIRTH th, Day, Year)		8. BIRTHE Country	PLACE (State or Fo	reign	
	213-44-8617	1 ⊠ M 2 □ F	47	YRS.	MORINS	DAYS	HOURS	Fe			, 1948 Marylan				
	9a. FACILITY NAME (If not institution, give str	eet and number)			9b. CIT	TY, TOWN C	R LOCATIO				-	C. COUNTY OF DEATH			
OH	1132 West Old Phi	ladelphi	a Road			Charl	Lesto	wn			Ce	ecil			
ב	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			T											
E				10c. CI1		OR LOCAT						10d. INSIDE CITY LIMITS?			
	Maryland Ce	cil			Ch		stown						1 YES 2 😾	NO	
FUNERAL DIRECTOR	1					101	ZIP CODE				HAT COUNTRY?				
W	1132 West Old Phi							914				ed S	tates		
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A		13	It yes, sp	ENDENT OF	HISPAN	IIC ORIOI	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black	- American India White, etc.	in,	
Β¥	3 Widowed 4 Divorced	IF YES, OIVE V					2 NO			, , , , , , , , , , , , , , , , , , , ,	- 1		White		
	15. DECEDENT'S EDUC	Vietn													
COMPLETED	(Specify only highest grade of	completed)	(0	Give kind of	work done	USUAL OCCUPATION ork done during most of working					SINESS/IND	DUSTRY			
اڄ	Elementary/Secondary (0-12)	College (1-4 or 5	+) T.7.0 #	opera	itor	·	t Plant US Gove								
N N			wat	er II	eati	ment			US Government Veteran Fac						
									NAME (First, Middle, Melden Sumame)						
TO BE	Carl Lee Speck							ldred Frances Wilson							
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow														
	Constance Diane Speck P. O. Box 256, Charlestown, MD 21914														
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place)											vn, State			
	Charlestown Cemetery 4/24 Charlestown,											, Maryla	and		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSÉE 22. NAME AND ADDRESS OF Crouch Funore														
	1/10la 14	11071					ch Funeral Home South Main Street, North East, MD 21901								
	23. PART I. Enter the diseases, pr co	emplications the	t caused the d	eath Do	not ante	z the go	de of duin	Mali	SU	reet, I	vortn	Last			
	snock, or neart failure. L	ist only one cau	se on each lin	a.	not ante	or trial into	ao or ayn	ig, suci	i es cai	diac or respi	ratory arr	wat,	Approxima interval Be	tween	
1	IMMEDIATE CAUSE (Final disease or condition	11 +	t fa				1,	1		4.4		14	Onset and		
	disease or condition resulting in death) a. Meta static Cancer of lunknown primary site												. 1 m	onth	
	DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequantially list conditions, b.	DUE TO	(OR AS A CONSE	OHENCE O	E).						-		-		
A	if any, leading to immediata cause. Enter UNDERLYING	502 10	(ON AS A CONSE	OUENCE O	r).										
윤	CAUSE (Disease or Injury that Initiated events	DUE TO	(OR AS A CONSE	OUENCE O	FI:										
Ē	resulting in death) LAST				. ,.										
E	d.														
4	PART II. Other significant conditions	contributing to	death but not	resulting	in tha u	ınderiying	causa gi	ven in	Part I.	24e. WAS AN			WERE AUTOPSY FIR		
5										PERFOR	4.0		AVAILABLE PRIOR 1 COMPLETION OF C		
PHYSICIAN: MEDICAL										1 123 %	4 40		OF DEATH?		
2	DID TOBACCO USE CONTR	IBLITE TO CA	USE OF DEA	ATH YE	:s 🖂	NO X	UNCE	DTAIR					1 YES 2 N	10	
A	25. WAS CASE REFERRED TO MEDICAL	IDOTE TO CA		CE OF DEA			OITCE		ч Ц						
잃		HOSPITAL:	EB/Outnetlant 1	2 004	OTHE		- W-								
ξ	27. MANNER OF DEATH	28a. DATE OF		28b. TIM		28c. INJ	5 Rea	Idence		SCRIBE HOW II	HIEN OO	OLUMED.			
	1 Natural 5 Pending	(Month, D		IN	IURY	WO	RK?		zeu. DE	SCHIBE HOW II	NUMT OC	UHED			
B	2 Accident Investigation 3 Suicide B Could get be	28a PLACE O	F INJURY — At he	ome ferm	etraat ta			-	204 1 00	ATION (0					
입	4 Homicide B Could not be	building,	etc. (Specify)	orne, remin,	arreet, tar	ctory, office			City	or Town, State)	na Number	or Hurel Ho	ute Number,		
<u>ا</u> پا	204 CERTIFIED										_				
린	(Check only														
COMPLETED	2 MEDICAL EXAMINER	On the basis of e	xamination and/or	Investigetio	on, In my	opinion, de	enth occure	d at the	time, date	e end place, an	d due to th	e cause(a)	and manner as st	ated.	
	296. SIGNATURE AND TITLE OF CHRTIFTEN						29c. LICEN	ISE NUM	BER		29d. DAT	E SIONED ((Month, Day, Year)		
8	1 Janlas	MD					1ת	531	4		Ap	r1/2	1, 199	5	
인	20 MARE AND ADDRESS OF DEDOM WILL	0040 5550 044					עע	L U L	- T		- 1		1111		

Chesapeake Hospice

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

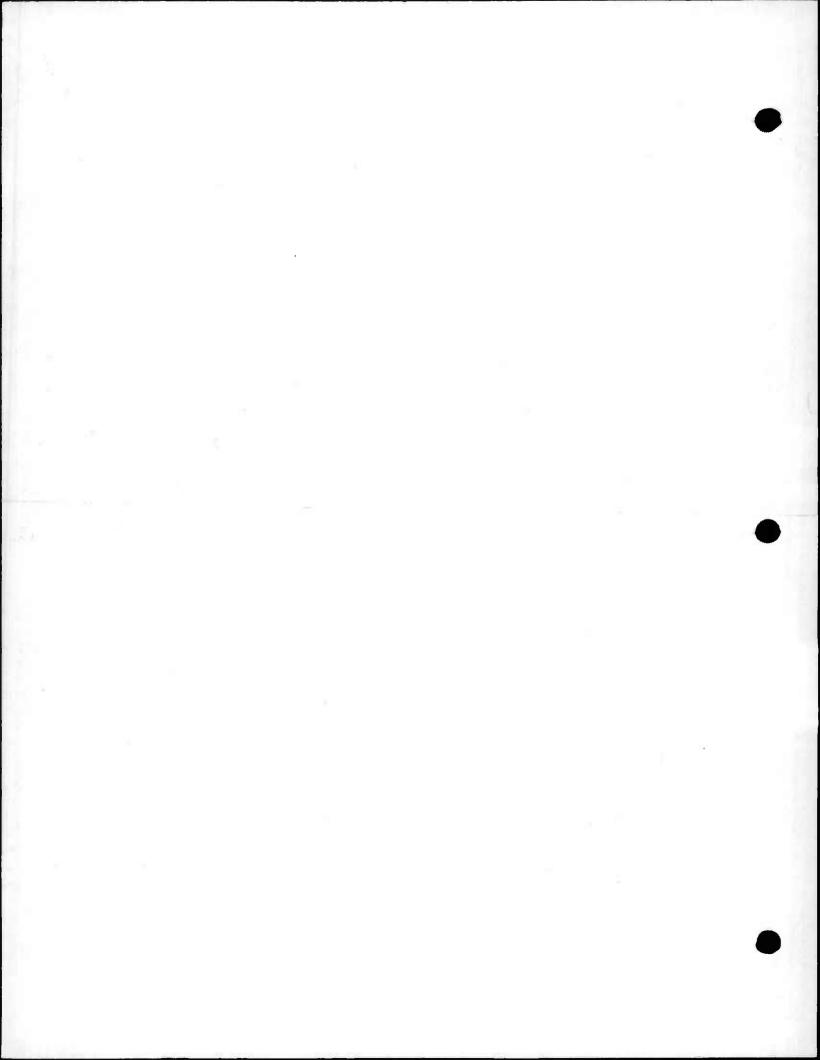
Northern (
32. REGISTRAR'S SIGNATURE
Dawler Randell

Dr. Henry Farkas 31. Date Filed (Month, Day, Velar) APR 24 1995 Jul

DHMH-16 Rev 1/89

Bridge Street MD 21921

239 S. Elkton,



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

		REGISTRAR			ENIIL	CATE O	PUEAIR		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH			IME OF DEATH
		DORIS MAY	SPANO	2190				MONTH			EAR	7100 "
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	at hirthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Apr	OF BIRTH			2105 M
		214-28-0909	1 M 2 K F	64	YRS.	MONTHS DAYS		(Monti	9 193	0 0	Country)	JE (State or Foreign
음				04	ma.				9 193	U	laryı	and
3 should		9a. FACILITY NAME (If not institution, give :				9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNTY	OF DEATH	1
23	ECTOR	Washington County	/ Hospital	1		На	gerstown			Was	shing	ton
	5	RESIDENCE OF DECEDENT										
Pages 1,	1 2 1	10a. STATE 10b. COUNT	Υ		10c. CITY	, TOWN OR LOC	ATION				10d	INSIDE CITY
م <u>د</u>	DIR	Maryland	Washingto	on		Hager	stown				1.	YES 2 NO
permit.	4	10e. STREET AND NUMBER					IOF. ZIP CODE			10g. CITIZEN		
	5	810 Medway Road					2174	0			J.S.A	
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	T FVFD WILLS AS								
21215-0020 B or attending physician, for use as the burial-tra	正	1 Never Married 2 X Married		YES 2 X		If yes,	ECENDENT OF HISPA specify Cuban, Maxic	NIC ORIGIN an, Puarto f	7 (Specify Yes a Rican, atc.)	or No- 14.	Black, Wh	merican Indian, ite, atc.
The b	BY	3 Wildowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 Y	ES 2 X NO Speci	ly:			Specify:	
as t	ED	45 0505051510 551	1								Whit	e
	쁘	15. DECEDENT'S EDU (Specify only highest grade		(G	iive kind of w	OSUAL OCCUPATION OF COMMERCE O	FION nost of working	16b.	KIND OF BUSI	NESS/INDUS	TRY	
	LET	Elementary/Secondary (0-12)	Callege (1-4 or 5+	///00	. Do NOT us	e retired.)						
thed ospit	COMPL	12		I	Homem	aker		H	er own	home		
AND the hospit detached	ō	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, A	Aiddle, Maiden S	(umame)		
at Be of	Ш	William Fred Rick	rott				Hazel :	Romai	ne Zoi	alar		
should should	00	19e. INFORMANT'S NAME (Type/Print)	CELL	1.00								
MARYLAND retained by the hospit should be detached notified at once.	0						t and Number or Rural					
y be r		Lawrence R. Spans	gler	8	310 M	edway F	load Hag	ersto	wn, Ma	ryland	1 217	40
MORE, age 6 may be director, page		20a. METHOD OF DISPOSITION 1 □ Burlel 2 ☒ Cremetion 3 □ Rem	ount from Ctota	20b. PLACE	ANDDATEO	F DISPOSITION (Nema of	DATE	E 20c. LOC	ATION — City	or Town, S	State
BALTIMORE, or death. Page 6 may be the funeral director, page val.		4 Donation 8 D Other (Specify)	IOVAI ITOM STATE	L Gemetery, cre	matory or oth	n Crema	tory 4-1	9-95	Hag	ersto	vn. M	aryland
- B - E		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	•		_	AND ADDRESS OF FA		11008		,	ar) rema
BALTIM hours after death. Page ed in by the funeral direct or removal. medical examiner n		5. 9/	mm				ch Funer		me			
Land the fundamental of the fund		OCONT!	11/6	mu	-l		. Wilson			Arcto	.771 M	a 21740
s after by the removal		23. PART I. Enter the diseases, or	complications that	caused the de	eth. Do n	ot anter the n	node of dving au	th as cerd	lac or resola	eton errest	VII.9 I	Approximata
hours after d in by th or remove		snock, or neart failure.	List only one ceus	se on aach line).						- 1	Interval Between/
filled on, o		IMMEDIATE CAUSE (Final	1000	110	>	1 70 1	. 1. 1		· lan	In de	-/	Onset end Death
matin t		disease or condition resulting in death)	1-20GPC.	1.414C	12841	13/8/8	day for the	5/1248	WWV,	NIIIK	U	2 sen
d within 4 ompletely filling, cremation, the			DUE TO	OR AS A CONSEC	QUENCE OF):	11			-		
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	ızı		L-				-					
executed and con to burial, matic en	No	Sequentially list conditions,	b	OR AS A CONSEC	DUENCE OF):						
racian clan	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	OR AS A CONSEC	DUENCE OF):						
racian clan	FICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c									
O. BOX ertificate be ing physician rgiene prior t	TIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	OR AS A CONSEC								
h certificate be ending physician I Hygiene prior to	ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c				1					
S, P.O. BOX death certificate be a attending physician tental Hygiene prior te ury, or other traur	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	OR AS A CONSEC	OUENCE OF):	,					
HDS, P.O. BOX at the death certificate be by the attending physician and Mental Hygiene prior t		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	OR AS A CONSEC	OUENCE OF):	ng cause given in	Part I.	24a. WAS AN A		24b. WEF	E AUTOPSY FINDINGS
UKDS, P.O. BOX that the death certificate be ed by the attending physician th and Mental Hygiene prior to any injury, or other traur		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	OR AS A CONSEC	OUENCE OF):	ng cause given in	Part I.		ED?	AVAI	LABLE PRIOR TO PLETION OF CAUSE
ires that the death certificate be signed by the attending physician feath and Mental Hygiene prior tws any injury, or other traur	IEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	OR AS A CONSEC	OUENCE OF):	ng cause given in	Part I.	PERFORM	ED?	CON OF I	LABLE PRIOR TO PLETION OF CAUSE DEATH?
HECONDS, P.O. BOX requires that the death certificate be been signed by the attending physician t. of Health and Mental Hygiene prior t shows any injury, or other traur	MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition	d	OR AS A CONSEC	OUENCE OF): n the underlyl		_	PERFORM	ED?	CON OF I	LABLE PRIOR TO PLETION OF CAUSE
AL HECOMDS, P.O. BOX be new requires that the death certificate be as been signed by the attending physician Oppt. of Health and Mental Hygiene prior to 23 shows any injury, or other traur	MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition DID TOBACCO USE CONT	d	death but not r	OUENCE OF	n the underlyi	UNCERTAL	_	PERFORM	ED?	CON OF I	LABLE PRIOR TO PLETION OF CAUSE DEATH?
IAL RECORDS, P.O. BOX The law requires that the death certificate be the has been signed by the attending physician ate Dept. of Health and Mental Hygiene prior to em 23 shows any injury, or other traur	MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	d	death but not ru	OUENCE OF): n the underlyl	UNCERTAL	_	PERFORM	ED?	CON OF I	LABLE PRIOR TO PLETION OF CAUSE DEATH?
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ON OF VITAL RECORDS, P.O. BOX OING PHYSICIAN. The law requires that the death certificate be Affer this certificate has been signed by the attending physician death with the State Dept. of Health and Mental Hygiene prior ts marked, or litem 23 shows any injury, or other traurs.	BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident	c. DUE TO (d	death but not reduced by the second s	TH YES OF DEATH	S NO NO OTHER: 4 Nursing Ho	UNCERTAL b) me 5 Residence JURY AT ORK? YES 2 NO	8 Other	PERFORM 1 YES 2 ((Specify) CRIBE HOW IN.	NO NO	AVAI CON OF I	LABLE PRIOR TO PLETION OF CAUSE PLATH? YES 2 NO
ON OF VITAL RECORDS, P.O. BOX OING PHYSICIAN. The law requires that the death certificate be Affer this certificate has been signed by the attending physician death with the State Dept. of Health and Mental Hygiene prior ts marked, or litem 23 shows any injury, or other traurs.	D BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Netural 5 Pending	c. DUE TO (d	death but not re	TH YES OF DEATH	S NO NO OTHER: 4 Nursing Ho	UNCERTAL b) me 5 Residence JURY AT ORK? YES 2 NO	8 Other 28d. DES	PERFORM 1 YES 2 [NO NO	AVAI CON OF I	LABLE PRIOR TO PLETION OF CAUSE PLATH? YES 2 NO
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DIVISION OF VITAL RECORDS, P.O. BOX BALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be AL DIRECTOR: After this certificate has been signed by the attending physician 72 hours after death with the State Dept. of Health and Mental Hygiene prior tit item 28 is marked, or Item 23 shows any Injury, or other traurit item 28 is marked.	E COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAL HOSPITAL: 1 Propertient: 28e. DATE OF Month, Da 28e. PLACE OF building, e	death but not reduced by the second s	TH YES OF DEATH DOA 1800. INJURIES INVESTIGATION OF THE STREET OF THE ST	Treet, factory, off	UNCERTAI DIVIDITY AT ORK? YES 2 NO Ite end place, end dua death occurred at the	8 Other 28d. DES 28f. LOCA City of	PERFORM 1 YES 2 (Specify) CRIBE HOW IN. ATION (Street and or Town, State) se(s) and place, and	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMAI COPE OPE 1 1 ED	Number,
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W. Charles

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

		REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO	D.	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN
		Elsie Izora Sh	irlev				April 1	iğ iğ	95 0345 "
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
		214-28-5519	1 DM 2 F	92 YRS.	MONTHS DAYS	HOURS MIN.	3-25-19	03	Maryland
3 should		9a. FACILITY NAME (If not institution, give s	treet and number))2	9h CITY TOWN	OR LOCATION OF DE		9c. COUNTY	
8. 18.	Œ			-01			Sin		
1, 2,	DIRECTOR	Washington Cou	nty nospi	val	nager	stown		Wash	ington
Pages		10a. STATE 10b. COUNTY	1	10c. CITY	TOWN OR LOCA	TION			10d. INSIDE CITY
	5	Maryland Was	hington	Bi	g Pool				LIMITS?
permit.	귛	10a. STREET AND NUMBER				M. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?
isi	18	11540 Ernstvil	le Road			21711			S.A.
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS	12 WAS DECEDENT EVER	IN U.S. ARMED	13 WAS DE		IC ORIGIN? (Specify Ye		
		1_ Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes, s	pecify Cuban, Mexica S 2 X NO Specify	n, Puerto Rican, atc.)	14 NO-	. RACE — American Indian, Black, White, etc.
ding of	B	3- Widowed 4 Divorced	in test are real on	JAT 23	I TE	S 2 20 NO Specify			White
215-0 attending use as the	8	15, DECEDENT'S EDU		16a. DECEDENT'S	SUAL OCCUPATI	ION	18b. KIND OF BL	ISINESS/INOUS	
- 6 - C		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during m retired.)	ost of working			
hospital ached to	르			Seamst	ress		Sewing	Fact	orv
the hose detach	COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NAI	WE (First, Middle, Malder		<u> </u>
3 B A		Joseph Henry P	ierce				E. Hull	/	
OKE, MAK 6 may be retained stor, page 5 should	BE	19a. INFORMANT'S NAME (Type/Print)	20200	19b. MAILING	ADDRESS (Street		loute Number, City or Tov		of a l
	일	Anna M. Summer	Q				RD. Big		
E gg L		2000 METHOD OF DISPOSITION		b. PLACE AND DATE O					
e 6 ma ector, p		1- Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from Stale	metery, cremetory or oth arkhead.	erplace)	ame or	1	CATION - City	
		21. SIGNATURE OF FUNERAL SERVICE LIC	chaes 🔿 .	arknead	Cemere	ery 4-1			ol, Maryland
ALIIN death. Pag funeral di		2	7/0/		Thom	nd aboness of facting	neral Ho	ome. I	nc.
M L 9 7	8	(rang/	Color		P. O.	Box 31	O Clear	Sprin	g. MD 21722
/m = 0 19		23. PART I. Enter the diseases, or o	omplications that cause	d the death. Do no					
Jag be	Ш	shock, or heart failure. IMMEDIATE CAUSE (Final	List only one ceuse on	each line.				,	interval Batween
within 24 pletely fills cremation, the		disease or condition	6	1. 11	17.	1			Onaet and Death
plete plete		resulting in death)	DUE TO (DR AS	A CONSEQUENCE OF	1 ava				24 Koury
a di di	_	_	Ti:	no le te	a Kan	1 1:	en en	-ff	Macro
OX 68/10 be executed sician and con- rior to burial, traumatic or	CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE OF	rear	i vara	la	-92	years
train siciar of	¥	if any, leading to immediate cause. Enter UNDERLYING		still I	1.11.				many
iffication of the part of the	ᇤ	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS	A CONSEQUENCE OF	e represen				7209
eath certi attending rtal Hygie Y, or ott	토	resulting in death) LAST							j'
e death he atten Mental H	빙								
三 音音音	A	PART II. Other significant condition	a contributing to death	but not resulting in	the underlyin	g cause given in I			24b. WERE AUTOPSY FINDINGS
ires that signed by Health an	EDICAL	aute Kenal Fa	ifwe with	mena	: dike	destise "	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
		Bost ingical re	Tole for the	words	9	wholesof p		23.40	OF DEATN?
v requ	2	DID TOBACCO USE CONTE	RIBUTE TO CAUSE O			UNCERTAIN			1 TES 2 NO
The law require has been ate Dept. of hem.	IAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEATH			. 2		
	SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:				
PHYSICIAN: this certifica with the Str	PHY	27. MANNER OF DEATN	28e. DATE OF INJURY	28b. TIME		IURY AT		M. II III	
2 美語書		1 Natural 5 Pending	(Month, Day, Year)	TOLKI INJU	RY WO	DRK?	28d. DESCRIBE NOW	INJURY OCCUR	ED
	B	2 Accident Investigation	28e. PLACE OF INJUR	K. Albama fama at		YES 2 NO			
ATTENDING ECTOR: After s after death	O I	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Spe	icify)	eet, lactory, onic	**	281, LOCATION (Street City or Town, State)		Rural Route Number,
DIRECT HOURS A	ш	0.000							
2 2 2 2 D	1		CIAN: To the beat of my know						
NERA Trin 7	COMPLET	2 MEDICAL EXAMINE	R: On the basis of examination	on and/or investigation	In my opinion, o	seath occured at the	lime, data end place, er	nd due to the co	suse(s) and manner as atated.
E FU d wit		29b. SIGNATURE AND TITLE OF CERTIFIER	/ /			29c. LICENSE NUM	BER	29d, DATE SI	GNEO (Month, Day, Year)
TO THE HOSPITAL IT OF THE FUNERAL IT DE FINE WITHIN 72 PER IMPORTANT: IT IT	BE (Thank	hode the	2		0020	557	1	1/10/00
FFA	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O	ATN (ITEM 27) (Type, I	Print)	2018	-	7.	11 1191
		30. HAME AND ADDRESS OF PERSON WAL	CE 1ED CHOOL OF O						
		Dr &B man	1190	0	tono (v	00-0 10	1000-1	\ .	ma niziral
		Dr & B Mood 31, PATE FILED (Month Many Year)	1 1190	Mt Gel	ma k	sad 19	agerste)Wh	md 21740
		Dr & B Mood 31 APPRILED (Marit 1995) July	A REGISTRAN SIG	Mt Gel	ma k	oad 19	lagerste)Wh	md 21740

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires, that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transf nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal,
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR	RTMEN	T OF H	EALTH DEAT	AND N		YGIEN	E		
	1. DECEDENT'S NAME (First, Middle, L Horace Francis		Jr.	-					2. DATE OF D MONTH April	EATH DA	100	YEAR	3. TIME OF DEATH 10:15 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (in yrs. ia	st birthday)		R t YEAR	IF UNDER	24 HRS.	7 DATE OF B	OTH		8. BIRTHE	PLACE (State or Foreign
	219-20-0937	1 🙀 M 2 🗌 F	66	YRS.	MONTHS	DAYS	HOURS	MIN.	Dec.	30,1	928	Pen	nsylvania
	90. FACILITY NAME (If not institution, (9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE				NTY OF DE	
5	11327 Manse Roa				I	Hage	rstow	n		_	W	ashi	ngton
DIRECTOR	10a. STATE 10b. CO		10c, CITY, TOWN OR LOCATION								tod. INSIDE CITY		
등	Maryland Wa	shington		Hagerstown								LIMITS?	
됩	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CITI		HAT COUNTRY?
띨	11327 Manse Roa	ıd	F 181				2	1740)			1	USA
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Vidowed 4 Divorced	IF YES, GIVE Y	XYES 2	RMED NO	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or					or No-	Black, Specify	— American Indian, White, etc. Thite	
8	15. DECEDENT'S	EDUCATION	16a. D	ECEDENT'S					16b. KIND	OF BUS	INESS/IND		Allice
<u> </u>	(Specify only highest (Elementary/Secondary (0-12)	College (1-4 or 5		Give kind of a. Do NOT u	se retired.)			g					
COMPLETED	8	0			bı	caker	nan			rail	lroad		
용	17. FATHER'S NAME (First, Middle, Last		0						WE (First, Middle,		Surneme)		
BE	Horace Francis 190. INFORMANT'S NAME (Type/Print)	Spalding,							Fogle				
5	19e. INFORMANT'S NAME (Type/Print) Lucinda Grunberg 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 18818 Rolling Road, Hagerstown, Maryland 2										d 21742		
	20a. METHOD OF DISPOSITION 1 Burlel 2 Commation 3 1	Removal from State	20b. PLACE cemetery, cri	AND DATE	OF DISPOS	SITION (Ne	me of	,	17-95			City or Tow	
	4 ☐ Donation 5 ☐ Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	- Hage	rstov			OTY			Hag	gerst	own,	Maryland
7	· CAN	478	n	6					L HOME				
	Since	100/	Com	U-E-C	41	5 E.	Wils	on B	1vd.,H	ager	stow	n,Md.	21740
	23. PART I. Entar the diseases, shock, or heart faile	or complications tha ire. List only one cau	t caused tha di use on each line	eath. Do r e.	not anter	tha mo	de of dylr	ng, such	aa cardlac o	or respl	ratory srn	est,	Approximata Intarval Batween
	IMMEDIATE CAUSE (Final disease or condition												Onset and Death
	reaulting in dasth)		OR AS A CONSE			ung							18 months
z			(01. 70 1. 001102	OULHOL O	,,.								
CERTIFICATION	Sequantisliy list conditions, If any, leading to immedista cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	OUENCE O	F):								
IFIC	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSE	OUENCE O	F):								
ERIT	resulting in death) LAST	d											
. 11	PART II. Other significant condi	tions contributing to	death but not	rasulting	In the ur	nderlying	cause o	lven in F	Part I. 24a.	WAS AN	AUTOPSY	7 24b. V	VERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL				177-4-17						PERFOR	MED?	1	MAILABLE PRIOR TO COMPLETION OF CAUSE
빌									_ '	TES 2	ZKNO		OF DEATH?
ä	DID TOBACCO USE CO	NTRIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO [UNC	RTAIN				i '	
S	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT									
YSI	1 YES 2 NO	1 Inpetient 2	ER/Outpatient 3	□ DOA	4 Nur	R: sing Hom	o 5X Ree	ildence 8	Other (Spec	city)			
	27. MANNER OF DEATH 1 🐰 Natural 5 🗌 Pending	28e. DATE OF (Month, D	INJURY ay, Year)	28b. TIM INJ	E OF URY		RK?		28d. DESCRIBE	N WOH	JURY OCC	URED	
B	2 Accident Investigati		E IN HIDY ALL		М		'ES 2 🗌						
COMPLETED	3 Suicide 8 Could not 4 Homicide determine	building.	F INJURY — At ho atc. (Specify)	zire, term, i	mreet, taci	iory, office			28f. LOCATION City or Town		nd Number	or Rural Ro	ute Number,
PLE	29e. CERTIFIER (Check only 1 X CERTIFYING PI	HYSICIAN: To the best of	my knowledge, de	eth occurre	ed at the I	lme, date	and place,	end due I	o the ceuse(e)	end man	ner an state	rd.	
0 №		MINER: On the beele of e											end menner ee stated.
w II	29b. SIGNATURE AND TITLE OF CERT))				29c. LICE	NSE NUME	BER		29d. DATE	SIGNED (Month, Day, Yeer)
0 8	Elwal	WD,X	Au				DOI	062	29d. DATE SIGNED (Month, Day, Year) ▶ 4/17/95				

217 W. Washington St.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

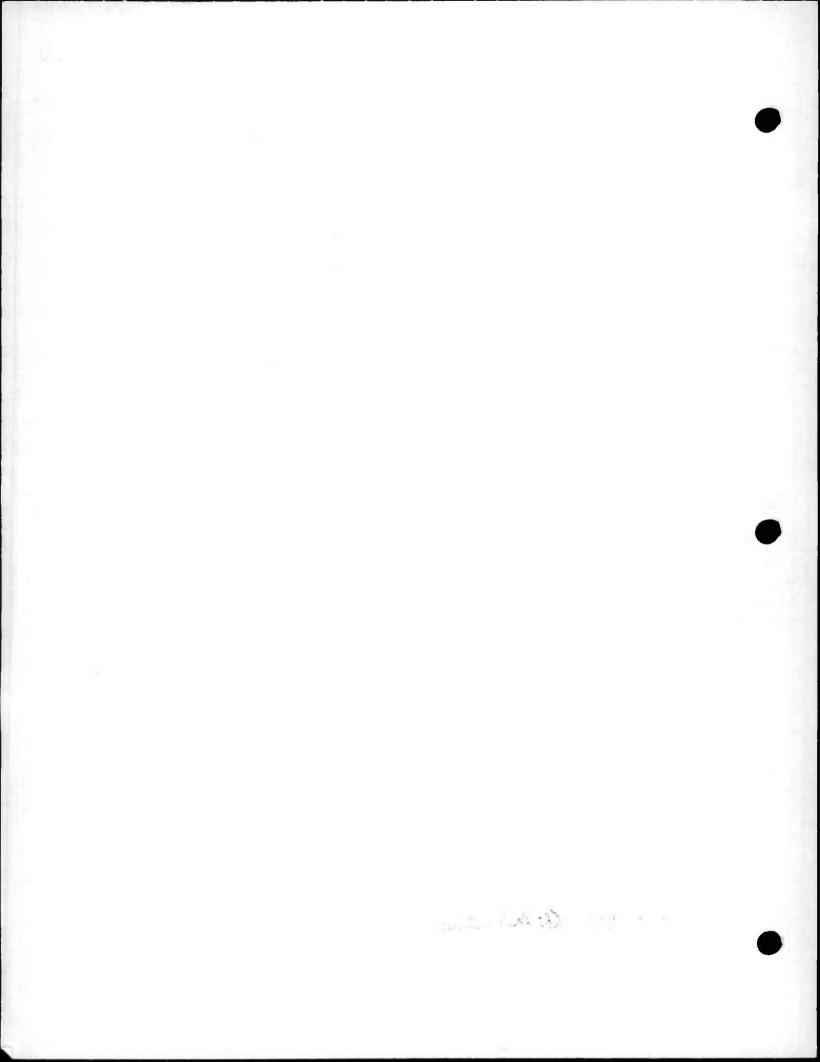
M.D.

III,

Edward W. Ditto,

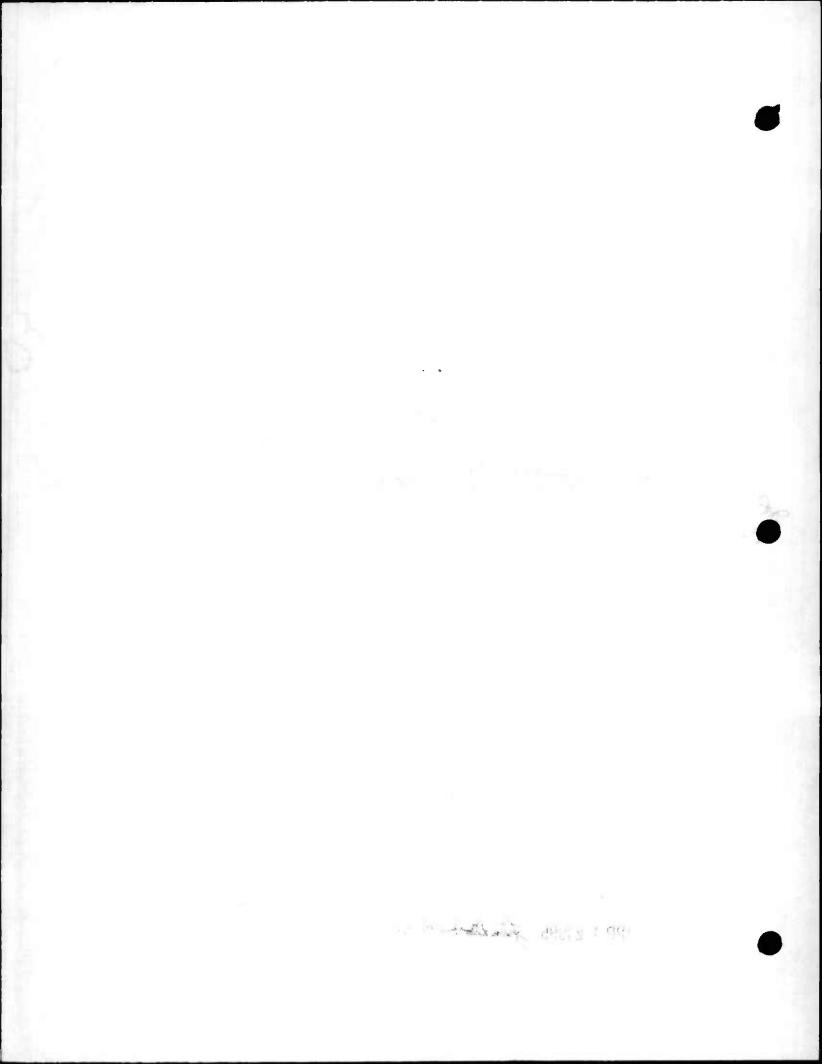
21740

Hagerstown, Md



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ILENDING PHYSICIANT. THE IAW REQUIRES THAT THE OBJATH CONTINCTOR OB EXECUTED WITHIN TAIL POOR BEAUTH. PAGE OF MAY BE RETAINED BY THE HOSPITAL OF ATTENDING DAYS.	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria	after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	29 is marked or item 23 shows any injury or other teaments award the marked eventions much be acuted at any
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	1 - STATE REGISTRAR	STATE OF MARYLAI		TMENT OF I		MENTAL HYGIEN REG. NO					
	1. OECEDENT'S NAME (First, Middle, Last) A. SOCIAL SECURITY NUMBER	EWEY	<u> </u>	ou	RS	April 1		3. TIME OF DEATH 03/6 A M			
	21730 5517	1 M 2 □ F 5	yrs. last birthday) 9 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cour	THPLACE (State or Foreign ntry) nnsylvania			
TOR	90. FACILITY NAME (If not institution, give st Washington Count				gerstown	ATH	9c. COUNTY OF Wash	ington			
DIRECTOR	10a. STATE 10b. COUNTY	islintan	10c. CIT	TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS? 1 VES 2 NO			
FUNERAL	100. STREET AND NUMBER 1041 Florida Ave	nue		10	21740		10g. CITIZEN OF	WHAT COUNTRY?			
B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 X YES IF YES, GIVE WAR OR DATE 1957	2 NO	If yes, sp	CENDENT OF HISPAN Heelty Cuban, Maxicar NO Specify		Spe	CE American Indian, ck Whita) atc.			
LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of v life. Do NOT us		ost of working		SINESS/INDUSTRY				
BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Commodore Dewey		sell-em	proyed		Ver ME (First, Middle, Melden Susan Nicl					
10 B	190. INFORMANT'S NAME (Type/Print) Jeannie C. Sours		1041	Florida	Ave., Ha	oute Number, City or Tow gerstown,		d 21740			
	20a. METHOD OF DISPOSITION 1 © Burlel 2 Cremetton 3 Removel from Stale 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of congriety, cremetary or other place) Rest Haven Cemetery 4-14-95 Hagerstown, Mar 21. SIGNATURE OF FUNERAL SERVICE LICENSE WINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 2										
RTIFICATION	23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING	Omplications that caused it clist only one cause on each DUE TO (OR AS A CO	he death. Do not hime. My ONSEQUENCE OF		ede of dylng, such		iratory arrest,	Approximate Interval Between Onset and Death			
	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):		uco pe					
MEDICAL (PART II. Other significant conditions Light Hier as	ton och	min	Got 1	Front w	Part I. 34s. WAS AN PERFOR		MARLARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100			
SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	PLACE OF DEAT	S NO C H (Check only one) OTHER:	UNCERTAIN			*			
D BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY 28e. PLACE OF INJURY 28e. PLACE OF INJURY 28e.	28h. TIME INJ	OF 28c INJ	PIK7 YES 2 NO		BE HOW INJURY OCCURED				
COMPLETE	4 Homicide datarmined 29s. CERTIFIER (Check only 1	building, etc. (Specify) HAN: To the best of my knowleds to On the beats of examination as	ge, death occurre	d at the Jime, data	and place, and due t	Othe cause(a) and men	vner as stated.				
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER	- m	D		29c. LICENSE NUM			D (Month, Day, Year)			
	30. HAME AND ADDRINGS PERSON WHO	completee cause of beath	(ITEM 27) (Type,	Print) St.	Hapen	Jours 1	nd 2	1740			



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner m
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95 13872 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO MARY 2. DATE OF DEATH 3. TIME OF DEATH APRIL 2.33 A. H 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign July 11.1934 220-28-3767 1 M 2 X F 60 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH University of Maryland Hospital Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN DR LOCATION 10d, INSIDE CITY Maryland Washington Hagerstown 1 YES 2 X NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13910 North Meadow Road 21742 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 17 yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 TYPE 2 NO Specify: 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married White В 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Homemaker COMPL Own Home 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Charles Alton Gabe Mary Catherine BE Mauk 19a. INFORMANT'S NAME (Type/Print) 19b. MA1LING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William G. Shank 13910 North Meadow Road, Hagerstown, Md. 21740 2pa. METHOD OF DISPOSITION
1X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Rest Haven Cemetery 04-24-95 Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew K. Coffman Funeral Home, Inc. R. heel Brea 40 East Antietam St., Hagerstown, Md. 21740 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallura. List only one cause on each line intarval Batween IMMEDIATE CAUSE (Final Onset and Death CAECAL CANCER & CLOSTRIDIAL GAS GANGRENE disease or condition resulting in death) months DUE TO (OR AS A CONSEQUENCE OF): SEPTICEWIA CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate OR GANI MUL TIPLE cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? ESLT 4 DIADETES. 1 TES 2 NO ВҰ

DID TOBACCO USE CONT	TRIB	UTE TO CAUSE OF DE	ATH Y	ES 🗆	NO UNCERTAI	N D		1 TYES 2 NO		
5. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND		26. PLA ### PSPITAL: Inpatient 2 ER/Outpatient	3 DOA	OTHE		8 🗆 Othe	f (Specify)			
7. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined		28a. DATE OF 1NJURY (Month, Day, Year) 28b. TIME OF 28c. 1NJURY AT WORK? M 1 YES 2 NO					26d. DEŞCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

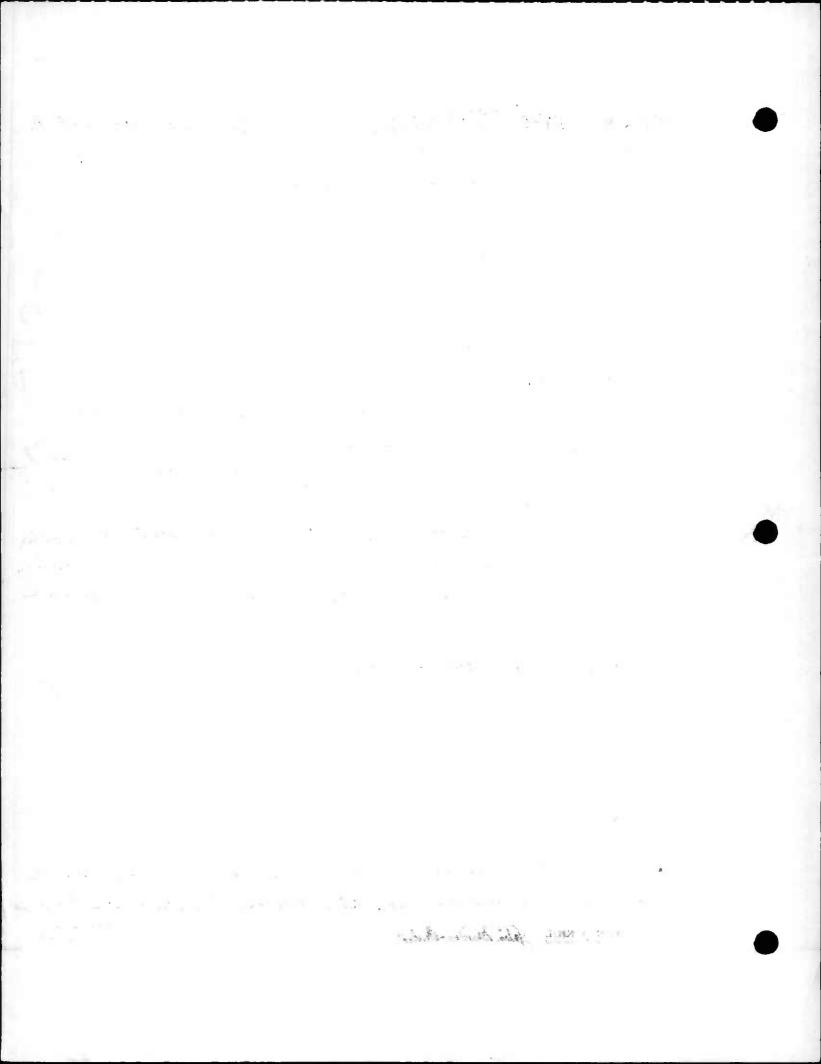
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated,

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year D23286 TRAUMA Sullion 1995 20

DDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1008 SHOCK TRIMING CONTER. UNIVOR MARKETINO. 225. GREENE Stra

MALKERND 21201

DHMH-16 Rev 1/89



3. TIME OF DEATH

1608

6. BIRTHPLACE (State or Fore

COMTARYLAND

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

SpeciWHITE

BROWN

1 YES 2 NO

OM

1995

9c. COUNTY OF DEATH

U.SA

WASHINGTON

10g. CITIZEN OF WHAT COUNTRY?

1907

REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 2PRI **ORPHA** LOUISE SHILLING 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 217-18-8812 FEB., 10,000) 88 1 M 2 X F Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR WASHINGTON COUNTY HOSPITAL HAGERSTOWN 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND WASHINGTON HAGERSTOWN permit. FUNERAL 10e STREET AND NUMBER 10f, ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 19727 SHILOH CHURCH ROAD 21740 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO BY 3 Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) COOK RESTAURANT once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at JOHN BOWMAN LILY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
16549 NATIONAL PIKE, HAGERSTOWN, MARYLAND 21740 9 EMMA V. SPRANKLE Pe 29s. METHOD OF DISPOSITION
1 Å Burlal 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must ROSE HILL CEMETERY 4 Donation 5 Other (Specify) 04-13-95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ANDREW K. COFFMAN FUNERAL HOME, INC. R. hall 40 E. ANTIETAM ST., HAGERSTOWN, MD. 21740 n by the fi removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reaplratory screat, shock, or heart failure. List only one cause on each line. filled in by **IMMEDIATE CAUSE (Fine)** disesse or condition_ and completely for burial, cremation abdominal artic Subterned other traumatic event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 physician a if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury OUE TO (OR AS A CONSEQUENCE OF): the attending p that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY signed by the PERFORMED? any 1 | YES 2 10 shows : t, of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: certificate has be the State Dept. WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DR ATTENDING PHYSICIAN: The **EXAMINER?** HOSPITAL: OTHER: 1 ☐ YES 2 ₩ NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? this c 264. OESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending DIRECTOR: After the hours after death vitem 28 is mark BY 1 YES 2 NO 2 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
(Check only one)

29 MENICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. HOSPITAL FUNERAL I = TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT; II 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

I w

TBOUL WATERD MO-12821-OAKHILL AVE

32. REGISTRAR'S SIGNATURE Jelia Sovieten Radall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

29c LICENSE NUMBER

12145

FOR

29b. SIGNATURE AND TITLE OF CERTIFIER

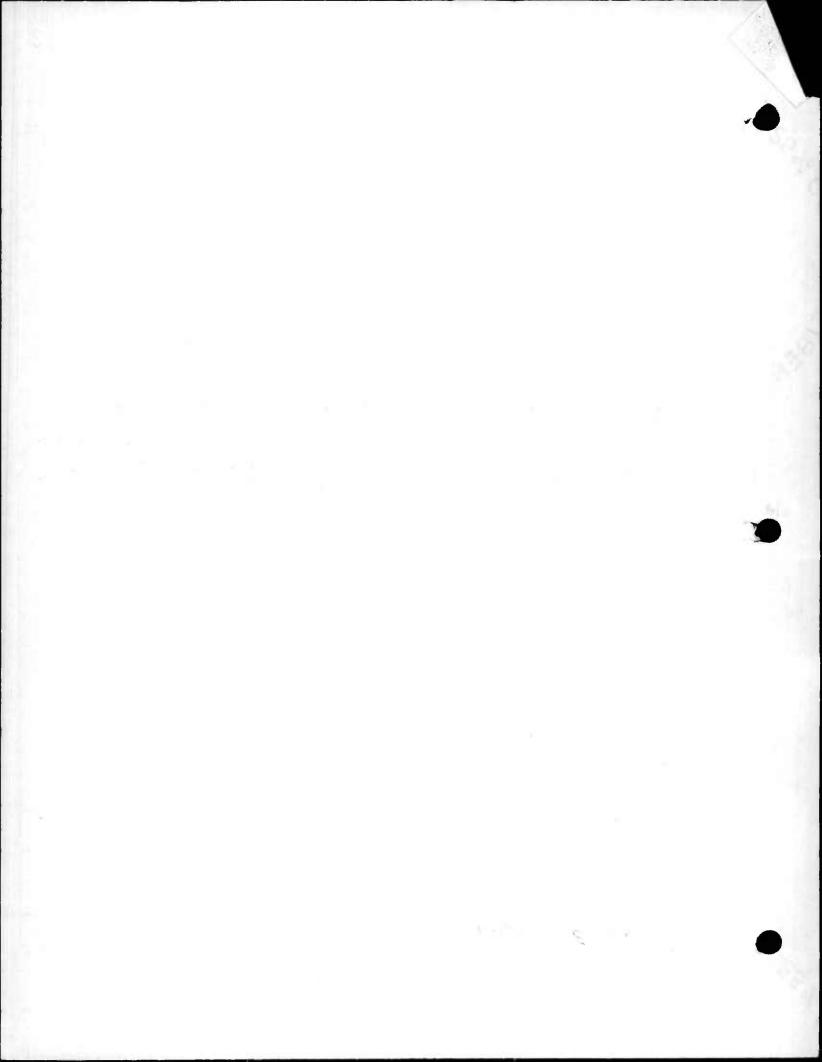
100 1 2 1995

31. DATE FILED (Month, Day, Year)

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20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND **Approximate** interval Between **Onset and Death** anecerysing Da 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 194 ACIERSTUNN MD DHMH-16 Rev 1/89



amended, - Itom # 6, 2/24/95; Harford County, 5. 3.5 13874

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1	_	STATE	
	_	REGISTRAR	

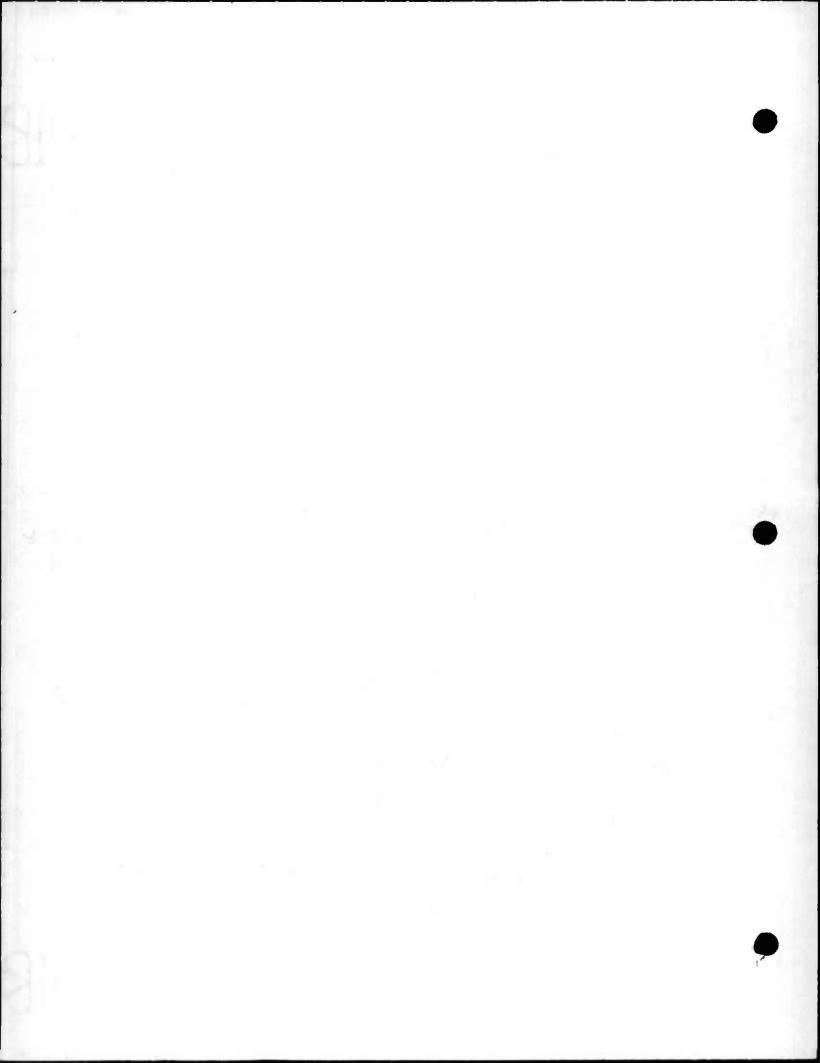
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE	JE DEATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) CLEVELA (VT)	TANNER S	conne	V		2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	,1995	MRTHPLACE (State or Foreign
011		255-16-7318	1 🔯 M 2 🗆 F	7372 YRS.	MONTHS DA		(Month, Day, Year) March 12	۰ ا	country)
though		9a. FACILITY NAME (If not institution, give	street and number)	1215	9b. CITY, TO	WN OR LOCATION OF D	Georgia of Death		
2.3	O.	926 Hamburg Dr.			Abin	gdon		Harford	
. S	ECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c CC	TY, TOWN OR LO	CATION			18d. INSIDE CITY
. Pages	E I	Maryland I	Harford	100.00	Abina				LIMITS?
permit.	AL.	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
sit		926 Hamburg Dr	•			21009		U	SA
20 ysicia irial-tr	FUNER	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No — 14.	RACE — American Indian, Black, White, alc.
21215-0020 al or attending physician. for use as the bunial-transit	BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			YES 2 NO Specif			Specify:
215-0020 attending physician se as the bunal-trai	0	15. DECEDENT'S ED	JCATION	18e. DECEDENT'S			18b. KIND OF BUS	SINESS/INDUST	<u>White</u>
- 6 -		(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done durings retired.)	g most of working			
the hospital detached	COMPL	6		Pa	inter			A -	ruction
	S	17. FATHER'S NAME (First, Middle, Last)	3				AME (First, Middle, Malden		
	TO BE	Dock Cleveland 19a. INFORMANT'S NAME (Type/Print)	Storey	405 44411 101	0.4000000.00		ld Lena (
5 5 5		Audrey C. Dorohov	zich				Aoute Number, City or Town		(e)
May be or, page		20a. METHOD OF DISPOSITION	201	. PLACE AND DATE	OF DISPOSITIO			CATION City	or Town, State
		1 N Buriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	1/4/	ardens of	other place) Of Fait	h Cemeter	y 4-24-95	Baltin	pore. Md.
2 _		21. SIGNATUME OF FUNERAL SERVICE L	Kefuser 1/0)	1	/ 22 NAM	F AND ADDRESS OF EA	CILITY		
- D TO		1 / mand	K /// // ~	1	Z 131	7 Cokesbur	y Rd., Abi	ngdon,	Home, P.A. Md. 21009
within Jurs within Jurs spletely filled in to cremation, or rer rent, the medi		23. PART I. Enter the diseases, by ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only ona csuse on e	each lina.			VASCULAR	?	Approximate intervei Between Onset and Daath
P.O. BOX th certificate be extending physician a il Hygiene prior to or other traum	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE O			DISE	ASE.	
ORDS, P that the death led by the atten th and Mental P any Injury, or	- 11	PART II. Other aignificant condition	ns contributing to death t	out not resulting	in the under	ying cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
that that I was an a san	MEDICAL	EMPHY					PERFOR	. /	AWAILABLE PRIOR TO COMPLETION OF CAUSE
requires that the signed of Health and shows and	ME							X	OF DEATH? 1 □ YES 2 YNO
23 by by Can		DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH	YES X NC			
N: The ficate has State D	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	B. PLACE OF DEATH (C)	eck only one)		
CIA!	PHYS	1 YES 2 NO	1 Inpetient 2 ER/Out	patient 3 DOA 28b. Til		Home 5 Realdence			
NG PHYS fler this cath with marked,		1 Natural 5 Pending	(Month, Day, Year)		JURY	WORK?	28d. DESCRIBE HOW I	NJUHY OCCURE	:D
J 5 4 5	ED BY	Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spe	/ — At home, larm,			281. LOCATION (Street of City or Town, State)	and Number or R	ural Route Number,
OR ATTENC DIRECTOR: hours after item 28 is	ETE	4 Homicide detarmined					Oily or lown, state)		
A P P P P P P P P P P P P P P P P P P P	COMPLET		BICIAN: To the best of my know ER: On the beste of examination						use(a) and manner as stated.
HE HE HE BE WITH	BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R DEGUT	Y MEDI	ICAL	29c. LICENSE NU	MBER	29d. DATE SIG	ONED (Month, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	TO B	Kuhard J. (Val	Cerimo a	EXAMINIT	YER	OCI	ME	MAR	120,1993
		30. NAME AND ADDRESS OF PERSON A	HO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Typ	e, Print)				
		31. DATE FILED (Month, Day, Year)	32 BECIETBADE SICA	ATUREA					
		APR 21 199	32. REGISTRAR'S SIGN	or local					

APR 21 1995 Juli Mandear Marchell

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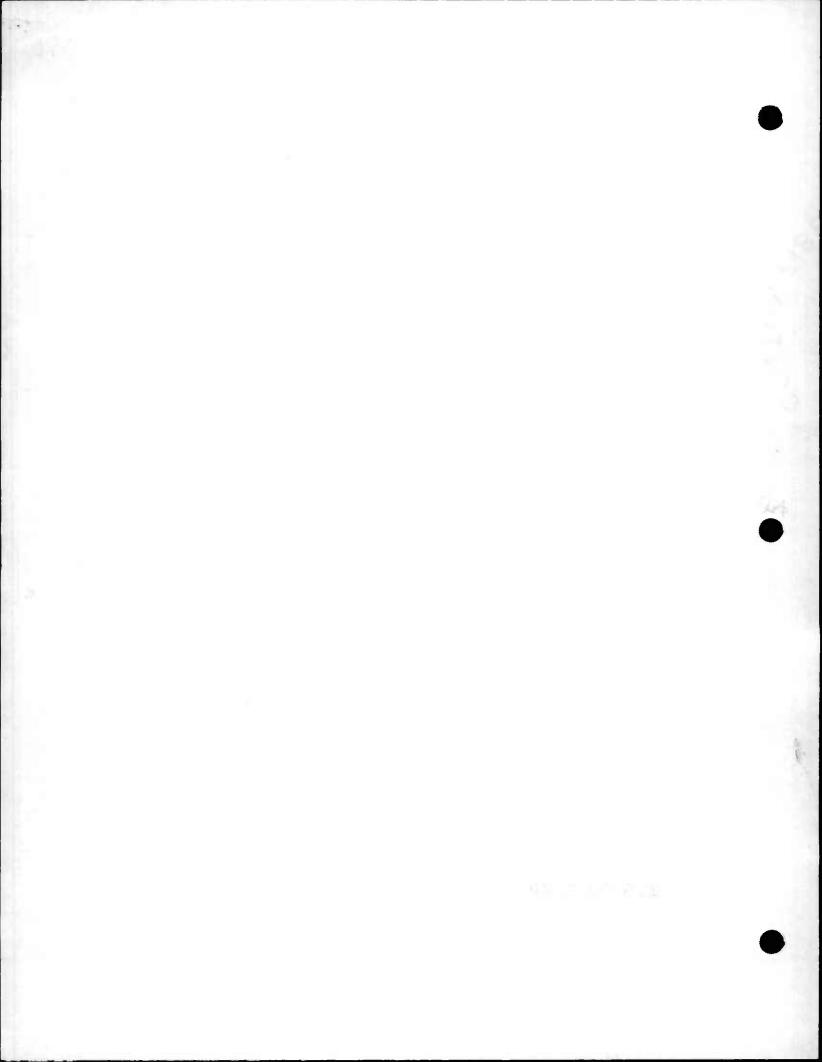
		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Lest)	2. DATE OF DEATH	3. TIME OF DEATH
		Harry Sugimoto	4-18-95	9:16 p M
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign
9		568-20-7020 1 ₹ M 2 □ F 92 YRS. MONTHS DAYS HOURS MIN.	12-3-02	Japan
3 should		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE	ATH 9c. C	OUNTY OF DEATH
1, 2,	DIRECTOR	Anne Arundel Medical Center Annapolis	A:	nne ARundel
Pages	R	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?
permit. F		Maryland Anne Arundel Severna Park		1 TES 2 X NO
	FUNERAL	10s. STREET AND NUMBER 10f. ZIP CODE		CITIZEN OF WHAT COUNTRY?
trans	y	202 Sycamore Road 21146		SA
215-0020 attending physician. se as the burial-transit	BY FU	11. MARITAL STATUS 1 Never Married 2 Married 1 VES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 NO 1 YES 2 NO 1	1, Puerto Rican, etc.)	14. RACE — American Indian, Black, Whita, atc. Specify: Asian
thend	ED	15. DECEDENT'S EDUCATION 184. DECEDENT'S USUAL OCCUPATION	16b. KIND OF BUSINESS/	
the hospital or att detached for use		(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use refired.) (Sive kind of work done during most of working life. Do NOT use refired.)		
	길	8 Gardener	Garden	ing
A be the detact	COMPI	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAI	ME (First, Middle, Maiden Surname	
retained by 5 should be notified at	101	Yuitsu Sugimoto Toshi	e Yoshida	
	TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural F		Zip Code)
		Marlene Sugimoto Same as # 10		
ALTIMORE, death. Page 6 may be tuneral director, page		20a. METHOD OF DISPOSITION 1 Burlal 2X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemelery, cremetory or other place)	DATE 20c. LOCATION	— Cify or Town, State
Me 6		4 Donation 5 Other (Specify) Metro Crematory 4-2	1-95 Catons	sville, MD
ALTI death. P funeral		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACE Barranco and		cal Homo
BAI ter dea				PArk MD 21146
hours after ed in by the or removal		23. PART I. Enter the diseases, or complications that studed the deeth. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	es cerdiec or respiratory	arreat, Approximate
20 P P P P P P P P P P P P P P P P P P P		IMMEDIATE CALICE (Final		Interval Between Onset and Death
d withing and withing the completely filled.		disease or condition resulting in death) . IKALT FAICULE PNU EM OY /		172Hms
68760 ecuted withing nd completely burial, cremat		disease or condition resulting in death) S. HEALT FAILULE IPNUEM OF A DUE TO (OR AS A CONSEQUENCE OF): PLOSTINE CANCINOMA		4.4
687 executed and con o burial,	S			/U/t
ior be O	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CALISE (Disease or letter)	7107	
m # } a	TIFIC	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):	OIL I	
A E T 2		resulting in death) LAST		
DS, P. the death of the attend	5 5	0.		
RDS, last the deat by the atternant Mental	g	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in HAD NUMBER SUNGER AT AMU	Part I. 24a. WAS AN AUTOPS PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
uires the	MEDIC		1 TES THO	COMPLETION OF CAUSE OF DEATH?
RECO w requires th been signed tt, of Health		H WIDEMATIC HAAT DIGAGE	~	1 TES NO
as bear	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)		
PHYSICIAN: The this certificate h with the State C	S	EXAMINER? OTHER:		
SICIAL Certification	. ¥	1 YES 27-NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Raeldence 27 MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW INJURY	COLUMN
		Netural 5 Pending (Month, Day, Year) N NURY WORK?	A I	r
J a do		2 Accident Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office	28f. LOCATION (Street and Num.	ber or Rurai Route Number
S and and and and and and and and and and		4 Homicide determined building, etc. (Specify)	City or Town, State)	VA
0 0 0 2		29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due	to the cause(a) and menner as	stated
SPITAL ERAL In 22	N O	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the		
THE HOSPITAL THE FUNERAL filed within 72	Ö	296. SIGNATURE AND TITLE OF CERTIFIED. 29c. LICENSE NUM		ATE SIGNED (Month, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	BE	66 h		4/15/95
FFA	일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		7.0
		EDWARD M. ZAGULA, M.O. GOORIDGELY AVE, ST.	EIRO. ANNI	trous mo Dian
			130111.	
		31. DATE FILED (Month, Day, 1681) 32. REGISTRAR'S SIGNATURE APR 21 1995		



) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, 3 should	led within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
THE H	TO THE FL	be filed wi	IMPORTA	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

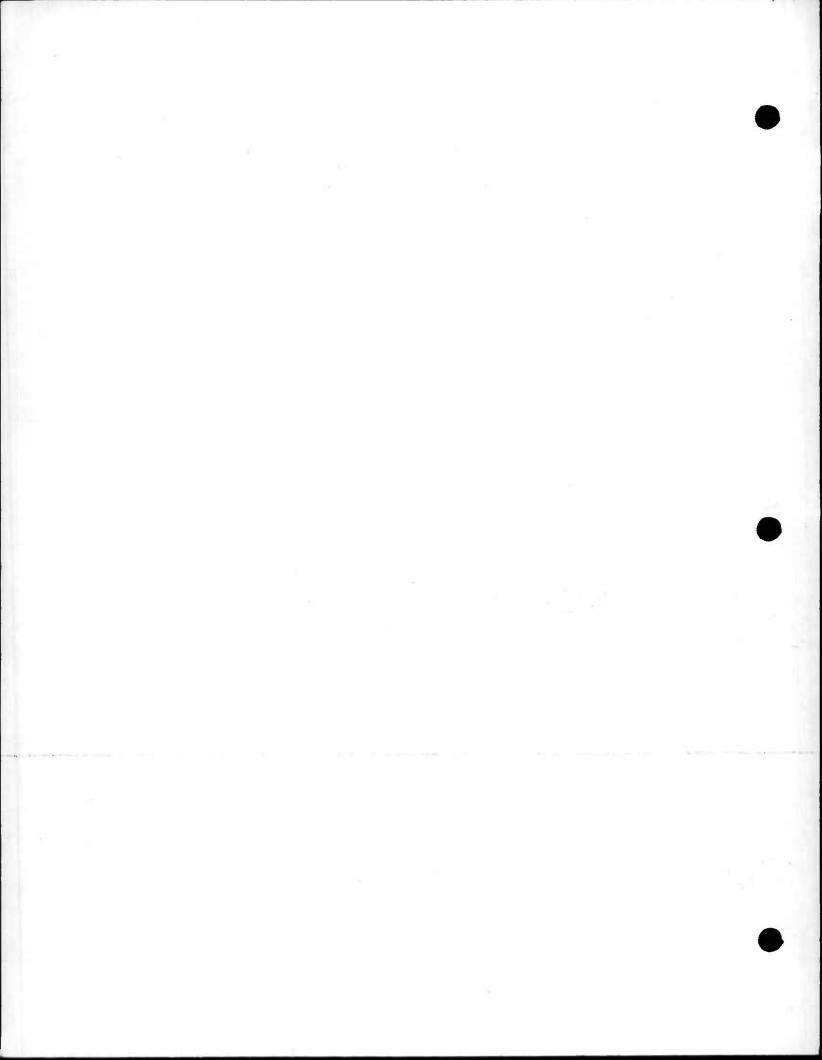
	1 - FOR STATE REGISTRAR	STATE OF M							NTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH									3. TIME OF DEATH			
	VINCENT F.						PRIL 12	1995	YEAR	12:30pm M				
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les		IF UNDER 1		UNDER 24 H	IN.	DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign		
Œ	212-60-0620 98. FACILITY NAME (If not institution, give	1X M 2 F	42	YRS.		4.00		N	OV. 20 1	_	MARYLAND			
						TOWN OR L		OF DEATH						
CTO	MERIDIAN SPAA				ANNA	POLI	5			ANNE ARUNDEL				
IRE	10a. STATE 10b. COUNT	10c. CIT	Y, TOWN OR	LOCATION				10d. INSIDE CITY LIMITS?						
LD	MARYLAND ANNE 100. STREET AND NUMBER	ARUNDEL		EI	OGEWAT	ER 101. ZIF	0000			T	1 X YES 2 NO			
BY FUNERAL DIRECTOR	139 DORSEY DRIV	E				037		10g. CIT	USA	VHAT COUNTRY?				
N N	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED	13. W	AS DECEND	ENT OF H	SPANIC C	ORIGIN? (Specify Ye	s or No-	io — 14. RACE — American Indian, Black, White, atc.			
.Y F	1 Never Married 2 Married 3 Widowed 4 Olvorced	IF YES, GIVE WA	MAR OR DATES 1 YES 2 TO NO Specify:							Speci	thy:			
	15. DECEDENT'S EDU	1979 -		05051710							BLA	CK		
ETE	(Specify only highest grade	e completed)	(Gi	ve kind of a Do NOT us	USUAL OCC work done du se retired.)	ring most of	working		16b. KIND OF BU	ISINESS/IN	DUSTRY			
IPL	Elementary/Secondary (0-12)	College (1-4 or 5+)		SICIA	N				SELF	F EMPLOYED				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18	MOTHER	S NAME (First, Middle, Maider	Surname)				
BE (DAVID SIMMS						M.	ARY S	SIMMS					
2	19a. INFORMANT'S NAME (Type/Print)								Number, City or Tov					
	MARY SIMMS		20b. PLACE				_	SWAI	ER, MD.					
	1 Burial 2 Cremation 3 Ran 4 Donation 6 Other (Specify)	noval from State	Cemetery cre	matory or e	F.T.F.RA	N CE	ME. 4	1/17	OATE 20c. LO	CATION — WNSVI		- C - C - C - C - C - C - C - C - C - C		
	Competer of computer of the co													
	Larry H-	Rose							ORTUARY, NNAPOLIS			01		
	23. PART i. Enter the diseases, pr	compilcationa that	caused tha de	ath. Do r								Approximate		
	shock, or heart tellure. List only one ceuse on each line. interval Between interval Daeth Onset and Daeth										interval Between			
		DUE TO (C	OR AS A CONSEC	DUENCE O	F):		`	. 9	21/2					
ON	disease or condition resulting in deeth) Sequentially list conditions, If any, leading to immediate Acquired Immune deficiency Syndrome dx'd DUE TO (OR AS A CONSEQUENCE OF): 2 1/2 DUE TO (OR AS A CONSEQUENCE OF):										2/2 1/13			
AT	csuse. Enter UNDERLYING MORE MANAGEMENT MANA											1 month		
E	CAUSE (Disease or Injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION														
	PART ii. Other significant condition	ns contributing to d	leeth but not re	esulting	n the und	erlying ca	use give	n in Pari			24b.	WERE AUTOPSY FINDINGS		
MEDICAL									PERFO	4		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ME										/		OF DEATH? 1 ☐ YES 2 Ø NO		
ä	DID TOBACCO USE CONT	RIBUTE TO CAU					JNCER	AIN [
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	H (Check on	, ,								
14S	1 YES 2 NO	1 Inpatient 2 I		DOA 28b, TIM	4 AUNursin	g Home 5 8c. INJURY			Other (Specify)					
	1 Neturel 5 Pending	(Month, Day,	Year)		URY 4	WORK?			d. DESCRIBE HOW	INJURY OC	OCCURED			
) BY	Accident Investigation Accident Investigation M 1 YES 2 NO							LOCATION (Street	and Number or Rural Route Number,					
COMPLETED	4 Homicide determined	building, et	ic. (Specify)						City or Town, State,)				
PLE	29a. CERTIFIER Check only	ICIAN: To the best of m	ry knowledge, der	th occurr	d at the tim	e, data and	place, and	due to th	he cause(a) and ma	nner as sta	ted.			
OM	one) 2 MEDICAL EXAMINI) and manner as stated.		
BE C	296. SIGNATURE AND TITLEDE CERTIFIER 296. DATE SIGNED (Month, Day, Year)										(Month, Day, Year)			
TO B	Myel m						D33	654	1	•	4/	14/95		
-	30. YAMJANSERLEIMITSUSYN	M.D.MPLETED CAUSE	o Adh	1 27] (Type,	Pringiocal	var	e n	۲,	Arragiol	シン	mo	11401		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR												
- 8	APR 1 8 1995	Julia Dav	clear Rend	all										



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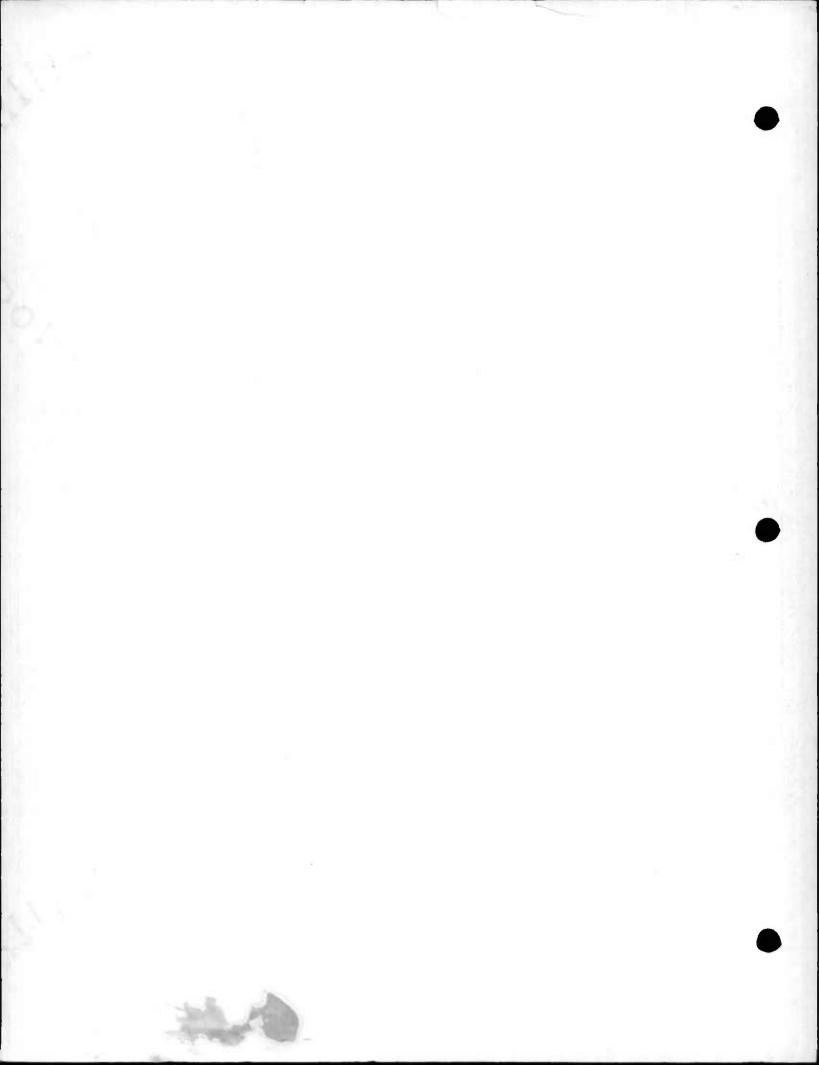
1	FOR STATE REGISTRAR	STATE	OF MARYLAN	ID / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
1	DECEDENT'S NAME (First,	Middle, Last)			2. DATE C	F DEATH
	George	Ignatius	Seybold		MONTH A TO 3°	7 199

		nedis i nan				CE	MILL	ICALL	CUF	DEATH		REG. NO			
		1. DECEDENT'S NAME (First,	Middle, Last)								2. [DATE OF DEATH		3	. TIME OF DEATH
		George	Ignat	ius Se	ybo1	.d						or 17 199		YEAR 5	:45am M
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE	(in yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER 24 HR	_	DATE OF BIRTH	1		ACE (State or Foreign
		164-14-068	3	1 🖾 M 2 🗆 F	89		YRS.	MONTHS	DAYS	HOURS MIN	. ('Month, Day, Year)		Country)	
should		9e. FACILITY NAME (If not in	_	(met and number)	0)			01-0171	. 200101	OR LOCATION OF		ь 23 190			imore MD
3 Sh	œ	Calvert Man			m o					Sun	DEATH		Ceci	TY OF DEA	тн
2,	DIRECTOR	RESIDENCE OF DEC		ising no	me			KIS	Tug	Suii			1 000.	- 1	
- SS -	<u>입</u>	10e. STATE	10b. COUNTY	,			10e CIT	Y, TOWN (201004	TION					
Pages	<u>=</u>	MD	Harf					rchv						, ,	Dd. INSIDE CITY LIMIT8?
permit.							CIIU	LCIIV						1	YES 2 X NO
	₹.	10e. STREET AND NUMBER	- 1							H. ZIP CODE			10g. CITIZ	EN OF WH	AT COUNTRY?
020 physician. burial-transit	FUNERAL	3350 Level	Kd							21028			USA		
Sicia ial-tr	5	11. MARITAL STATUS		12. WAS DECEDEN				13.	WAS DE	CENDENT OF HIS	PANIC O	RIGIN? (Specify Yes	or No-	14. RACE -	- American Indian,
6 g	ВУ	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE			U			pecify Cuban, Mea S 2 X NO Sp		erto Rican, etc.)		Specify:	Vhite, etc.
215-0020 attending physician. se as the burial-trar		3 Millowed 4 Divo	rcea		1								1	white	
atte	E		EDENT'S EDU			16a. OEC	EDENT'S	USUAL O	CCUPATI	ION		16b. KIND OF BUS	SINESS/IND	JSTRY	
12 al or 10 to 10	<u> </u>	Elementary/Secondary (0		College (1-4 or 5	+)	life.	Do NOT us	e retired.)	uumg m	ost of working	- 1				
D spit	<u>a</u>	unknown				Eng	inee	ring	Fi	rm		Engine	eer		
AND 212- the hospital or att detached for use once.	COMPLET	17. FATHER'S NAME (First, MI	iddle, Last)								NAME (F	First, Middle, Meiden			
3 8 E	Ш	James	Sev	bold						Mimmi			,		
MAR retained 5 should notified	00	19a. INFORMANT'S NAME (7)				196	MAILING	Anners	2 (Street			Number, City or Town	- Ctata Tia	Cod-1	
	2	George I.	Saybol	d		1								C000)	
may be or, page		20e, METHOD OF DISPOSITI		u		_				d Churc			<u> 21028</u>		
e 6 may ector, p		1 Burlet 2 XCremetto	n 3 🗆 Reme	oval from State	carr	netery, creft	atory or o	ther place)			1		CATION C		
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		4 Donation 5 Other			_ R	A Fe	rris			17 1995		Wes	t Che	ster,	PA
ALTIM death. Page e funeral direct.		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE				22. R	NAME A	HO ADDRESS OF	FACILITY	al Home			
AL dear fun		- TOTAL	1/2										Yearn MT		011
hours after of in by the or removal.	-	23 PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
hours after d in by th or remova		shock, or ne	eart fellure.	List only one cau	se on e	ach line.	11. 00 1	iot enter	trie irie	oue or dying, a	uch mm	cardiac or reapi	ratory arre	rat,	Approximata Interval Batween
	- 1	IMMEDIATE CAUSE (Fin	el	(7	1	- 1	- 1							Onset and Death
t and t	Į	resulting in death)	→ ,		-AN	CPA	- 1	bu	m	0					2401
P.O. BOX 68760 th certificate be executed within 24 in hygene prior to burial, cremation, or other traumatic event, the				out to	(OR AS A	CONSEC	JENCE O	h: C		1 D					
687 ovecuted and com burial,	Z	Commendation that are dist		(V)	Nel	aaf	Tic	CA	NGC	NOK	:hs				141.
DX De exception of the control of th	CERTIFICATION	Sequentially list conditi- if any, leading to immed		DUE TO	(OR AS A	CONSEC	JENCE OF	ን፡							1111
BO ate b	S	CAUSE (Disease or Injur		h											
.O. B. certificate ding physi tygiene pr	틸	that initieted events		DUE TO	(OR AS A	CONSEC	JENCE OF	ን:							
P.O. th certif	E	resulting in deeth) LAST	Γ	1											
		DART II OU													
ORDS, that the des the at the at the at the at the and Ment, any injury,	MEDICAL	PART II. Other algnificer	nt condition	contributing to	death b	ut not re	sulting i	n the un	derlyln	g cause given	In Pert	I. 24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS
RECOR requires that een signed by of Heatth an	8											1 TYES 2		C	OMPLETION OF CAUSE
다 를 양물 때													T		YES 2 NO
. 305 -		DID TOBACCO US	SE CONTR	IBUTE TO CA	USE O	E DEAT	H YE	SIL	VO F	UNCERTA	IN E	a		1 '	_ 123 2 _ NO
12 6 8 g 7	Ž	25. WAS CASE REFERRED TO				26. PLACE			-		7	-			
N: T N: T State	PHYSICIAN:	EXAMINER?		HOSPITAL:				QTHER	1 :						
Certificial the	¥	27. MANNER OF OEATH		28a. DATE OF		Hatterit 3		_		ne 5 🗌 Residend	-				
NG PHYSIC frer this ce eath with th		~~	Pending	(Month, D			28b. TIMI	URY	WC	JURY AT DRK?	28d.	DESCRIBE HOW II	HJURY OCC	JRED	
ONG Poling After death	P.	2 Accident	nvestigation					M		YES 2 NO					
ATTEND CTOR: A after d after d 28 is	B		Could not be	28a. PLACE O building,	etc. (Spec	— At hom ⊯fy)	e, ferm, s	dreet, fect	ory, offic		281.	LOCATION (Street e City or Town, Stete)	nd Number o	r Rural Roul	e Number,
OR ATTENDING I DIRECTOR: After hours after death Item 28 is mail		Tomiciae 0	- Continued												
DIV L OR A DIREC hours	2	290. CERTIFIER (Check only	FYING PHYSIC	MAN: To the best of	my knowi	ledge, deat	h occurre	d at the ti	ime, date	end place, and d	ue to the	cause(s) and men	Der es state	d .	
PITAL ERAL 72 T	COMPL														nd menner ee stated.
HOSPITAL FUNERAL WITHIN 72 H		294: SIGNATURE AND TITLE													
世 世 温 夏	H	A A TO A	OF CENTIFIER) A)	121	10			29c. LICENSE N	UMBER		29d. DATE	SIONED (M	onth, Day, Year)
2 6 3 ₹	0	Made	our	That	41	7-1	all	m		1)094	62	~	14	11719	15
	- I	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DE	ATH THEM	27) (Type,	rint)	,			N 1 1	0		
		2011/124	WAD (mich	-Kd	1)(MAI	N9	oh	mid.	210	34-18	1 X 30	00	
		31. DATE FILEO (Month, Day,)		32. REGISTRA	R'S SIGN	ATURE						1			
		APR 1 8 1	995	Julia davi	Gor-A	arball									



NAME STIDOMS, Wells SR.	DIVISION OF VITAL RECORDS, P.O. BOX 68760	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within =5 houls after death. Page 6 may be retained by the hospital or attending physician.	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should? hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
A	DIVISION	AL OR ATTENDING	AL DIRECTOR: After 2 hours after death	

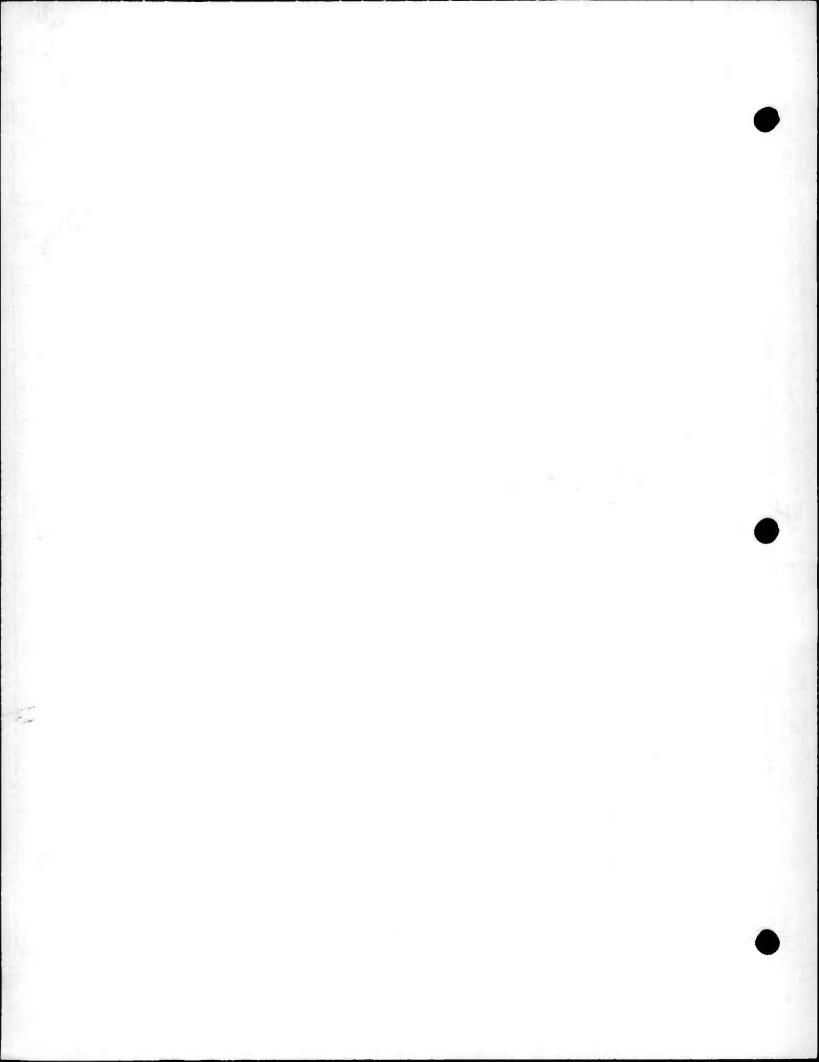
		FOR STATE REGISTRAR	STATE OF MARYLAND / DEPA CERTI	RTMENT OF H	IEALTH AND N	MENTAL HYGIEN REG. NO.		10070			
		1. DECEOENT'S NAME (First, Mindle Last)	stidoms Si	2.		2. DATE OF DEATH	4 9	3. TIME OF DEATH			
ъ	9	Aut a alant	SEX 6. AGE (In yrs. last birthday M 2 F 73 YRS.	MONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Z 8. Bif	ATTHPLACE (State or Foreign unity)			
2, 3 should	OR	9a. FACILITY NAME (If not institution, give special Company)	and number) Spital	9b. CITY, TOWN C	OR LOCATION OF DE	ATN	9c. COUNTY OF	DEATH			
-	DIRECTOR	10a. STATE 10b. COUNTY	Pop! 10c. C	ITY, TOWN OR LOCAT	TION /			10d, INSIDE CITY LIMITS?			
physician. burial-transit permit. Pages		100. STREET AND NUMBER	HERMAN Hichury	101	1. ZIP CODE 197	/	10g. CITIZEN O	1 VES 2 NO			
g physician. e burial-tran	BY FUNERAL	11. MARITAL STATUS 12 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO 1F YES, GIVE WAR OR OATES	If yes, sp	CENDENT OF HISPANI ecity Cuban, Maxican 2 NO Specify		В	ACE — American Indian, leck, White, alc, pocity:			
the hospital or attending physician, detached for use as the burial-trar once.	ЕТЕО В	15. DECEOENT'S EDUCAT (Specify only highest grade cor	npleted) (Give kind o	S USUAL OCCUPATE I work done during mo usp retired.)	ON ost of working	16b. KIND OF BUS	,				
the hospital of detached for once.	COMPLE	Elementery/Secondary (0-12) 17. FATHER'S NAME (Figst, Middle, Last)	College (1-4 or 5 +)	Arrence	18. MOTHER'S NAM	TRUC ME (First, Middler)Meiden	Surname)	P			
retained by th 5 should be d notified at o	BE	19a. INFORMANT'S NAME (Typo/Prigt)	TIGOMS 196. MAILIF	IG ADORESS (Street a	ROSA	A KICKI toute Number, City or Tou	MRdSO	a)			
2 2	2	NORMA STIDO	W/S 691 A	1905 TINE	DERMAN.	Highway	ELKH CATION -JOHY OF	M, MJ 21921			
Page 6 ma al director, g ner must		Burlel 2 Cremation 3 Remova Donation 5 Other (Specify) 21. SIGNATURE OF FUNEBAIR SERVICE LICEN	02/0	to cea	NO ADDRESS OF FAC	4/19	Ofra	Ja 19363			
is after death. Page 6 may be it by the funeral director, page removal.		► Edward	Moly	VI	is Frence	e storme c	Hedr	19363			
filled in line, or re		IMMEDIATE CAUSE (Final disease or condition	t only one cause on each line.		de of dying, auch	n aa cardiac or reapi	ráfory arrest,	Approximete interval Batween Onset and Daath			
executed within and completely o burial, cremati matic event,	7	resulting in death) a	DUE TO (OR AS A CONSEQUENCE ASCUD	OF):				3day			
be cian lor t	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE Diabite Miller.	OF):							
death certificate e attending physi ental Hygiene pr ury, or other t	CERTIFIC	CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST d									
a to T	AL	PART II. Other eignificant conditione of	ontributing to deeth but not reculting	in the underlyin	g ceuee given in i	PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
requires theen signed of Health	: MEDIC	DID TOPACCO HEE CO	ANITOIDITE TO CALIER O	F BEATH W		1 YES 2) (NO	OF DEATH?			
d: The law cate has b State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	ONTRIBUTE TO CAUSE O	26. PI	LACE OF DEATH (Che		<u></u>				
PHYSICIAN this certifi with the riked, or		27. MANNER OF OEATN 1 Netural 5 Pending	Inpatient 2 ER/Outpatlant 3 DOA 28a. OATE OF INJURY (Month, Day, Year) 28b. T	ME OF 28c. INJ	PRK?	8 Other (Specify) 28d. OESCRIBE NOW II	NJURY OCCURED				
TTENDING TOR: After after death 28 is mail	red BY	2 Accident investigation 3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY — Al home, farm building, atc. (Specify)		17	28f. LOCATION (Street a City or Town, State)	and Number or Run	al Route Number,			
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that in the FUNERAL DIRECTOR: After this certificate has been signed by be filled within 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any in the Dept.	COMPLET	1	N: To the beat of my knowledge, death occu On the beals of examination and/or investiga					e(e) end manner ea stated.			
THE HOS THE FUNI filed withi	BE CC	296. SIGNATURE AND TITLE OF CERTIFIER OU CUT (YOU M D)			29c. LICENSE NUM 0482	BER	29d. DATE SIGN	ED (Month, Day, Year)			
₽ ₽ 3 %	5	30. NAME AND ADDRESS OF PERSON WHO CO						4 95.			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	est, Trect	~	Iktor M	a 119	21.			
		APR 1 7 1995 July	t to more than the total of					DHMH-16 Rev 1/89			



3	2	452
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, parts find within 20 hours after death with the State Dear of Health and Mental Hydren prior to harda cremation or removal	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must b
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after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first within 72 hours after death with the State Dent of Health and Mental Hoolene prior to hurlal cremation, or removal	Cal
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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR ERTIF	TMENT	OF HEAL	TH AND	MENTA	L HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA	SLICER		SC	CHENCI	ζ		MONT	2. DATE OF DEATH DAY APRIL 12, 1995			3. TIME OF DE	P.	
		4. SOCIAL SECURITY NUMBER		E (In yrs. les	t birthday)	IF UNDER 1	YEAR IF U	NDER 24 HRS.	7 DATE	OF BIRTH			PLACE (State or		
		265-38-8632 9a. FACILITY NAME (# not institution, give st	1 M 2 K F	88	YRS.			CATION OF D		h 5, 1		laryI	and		
1	OR	Dulaney Towson Nu				Tows		SATION OF D	CAITI		Balt				
	DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCATION					$\overline{}$	10d, INSIDE C	ITY	_
		Maryland Baltin	more		Tot	wson							LIMITS?	□ NO	
	FUNERAL	6 Midcrest Court					10f. ZIP	L286			1		HAT COUNTRY	?	
	FUN	11. MARITAL STATUS 1 Never Married 2 Merried	IN U.S. AR	MEO	13. W	S DECENOE		NIC ORIGIN	i? (Specify Ye		14 BACE	- American Ir White, atc.	idlan,		
	BY	3 🖾 Widowed 4 🗌 Divorced	DATES			YES 2			,		Specify				
	ITEO	15. DECEDENT'S EOUC (Specify only highest grade	completed)	(G)	ive kind of v	USUAL OCC	UPATION ing most of v	orking	186	. KIND OF BU	SINESS/INDU	JSTRY	-		
eš .	COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) 6 years Elementary School Teacher Education													
at once.	- 1	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)													
notified	TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co.										Code)			_
2	۴	John E. Schenck 6 Midcrest Court, Towson, Maryland 21286 20s. METHOD OF DISPOSITION 1 Burles 2 Thermouling Town State 20b. PLACE AND DATE OF DISPOSITION (Name of agreeing, grematary or other place). 20b. PLACE AND DATE OF DISPOSITION (Name of agreeing, grematary or other place).											_		
examiner must		4 Donation 8 Other (Specify)		metery crei	majory of of Feri	her piece &	Compa	iny					ter, P	Α	
amine		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					Foard	ACILITY	eral H					
cal ex	_//	23. PART I. Enter the Assesses, or c	of pilostions that agus	ad the de	oth Do -	111	S. (ueen	St.,	Risin	g Sun	, MD			
or other traumatic event, the medical		shock, or heart feliure. I	List only one ceuse on	esch ilne	1							est,	Approxi Interval Onset s	Betwee	
it, th		disesse or condition resulting in death)	DUE TO (OR AS		cus/	ar (LUA	1Stri	cic	mry			ou.	yen	1
tle eve	z		DOE TO (OR AS	A CONSEC	DUENCE OF	·):									
ranma	ERTIFICATION	Sequentisily list conditions, if sny, leading to immediate cause. Enter UNDERLYING													
other	LIFIC	CAUSE (Disesse or Injury that initieted events	DUE TO (OR AS	A CONSEC	DUENCE OF):									_
اخ	CER	resulting in dasth) LAST	l												
를	CAL	PART ii. Other significent conditions	contributing to deeth	but not re	esuiting i	n the unde	riying ceu	se given in	Part i.	24a, WAS AN PERFOR		1	WERE AUTOPSY AVAILABLE PRIC COMPLETION O	OT RO	
23 shows any	MEDICAL									1 TES 2	NO	1	OF DEATH?		
	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
	PHYSICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 — YES 2 NO	HOSPITAL:			OTHER:		Residence	S □ Othe	r (Specify)					_
ked, or	PH	27. MANNER OF DEATH Netural 5 Pending	28a. DATE OF INJUR (Month, Day, Year		28b. TIMI	E OF 26	C. INJURY A	Т	_	CRIBE HOW I	NJURY OCCU	JREO			
60	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJU	RY At hor	me, farm, s		1 YES	2 NO	28f. LOC	ATION (Street	and Number o	or Rural Ro	oute Number,		_
28	ETE	4 Homicide detarmined	building, atc. (5)	овспу)					City	or Town, State)					
IMPORTANT: If item	COMPL		CIAN: To the best of my know.												
RTAN	ш	296. SIGNATURE AND TITLE OF CONTINEN	110					LICENSE NU		and piace, an			Month, Day, Yes		_
IMP	TO B	30. NAME AND ADDRESS OF PERSON WHO	YUN OU	Maria description	107.7	2.00	V	113	27	1	> 4	-13	3-95		
		Robert E. Stoner					e Dr.	, Tows	son,	Md. 2]	204				
		31. DATE FILED (AAP PY 1983 1991	32 MEDISTRATE SI	CAN KA	rdall										

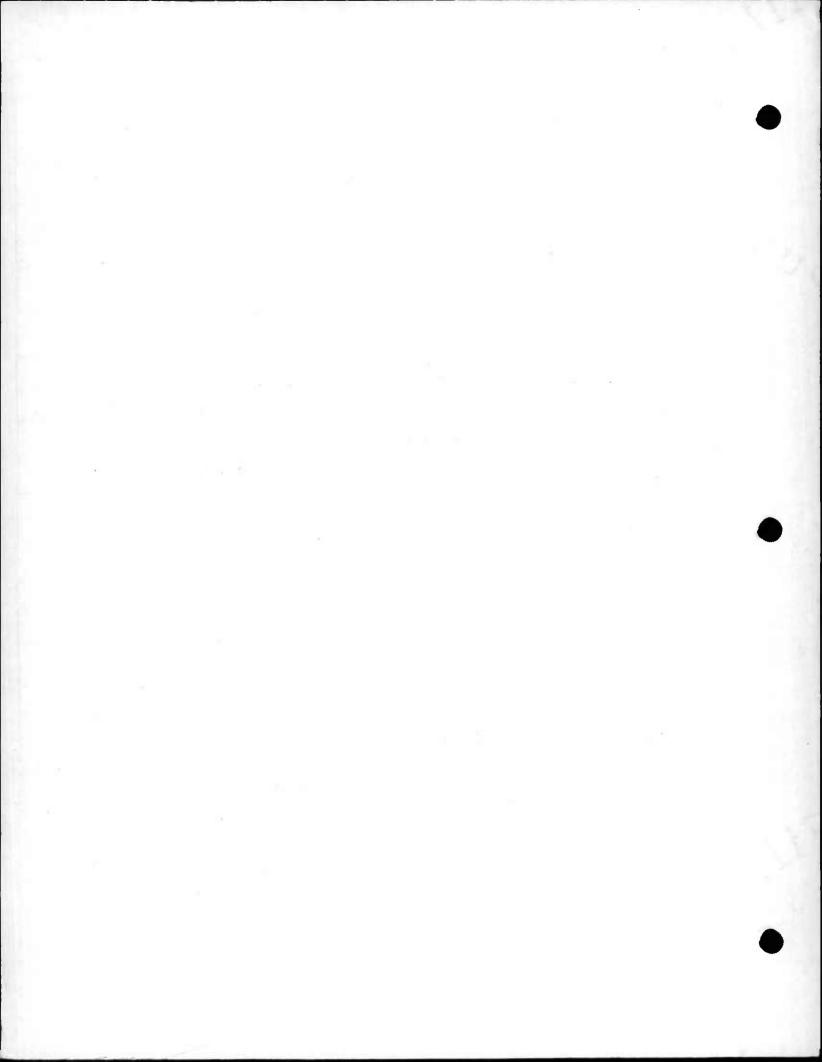
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

		REGISTRAR		CERTI	FICATE C	F DEATH	REG. N	0.					
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEA											
		BRIAN KEIT	Ή	TONEY	APRIL 12 95 1210F								
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		5 1210P M BIRTHPLACE (State or Foreign				
		218-02-9115	1 P 4 0 D 6		MONTHS DAT		(Month, Day, Year)		Country)				
pino		9a. FACILITY NAME (If not institution, give	1 X /	8 YHS.	at City To	NAL OR LOCATION CO.	lOct.10.1	966 W	ashington, D.C.				
5-0020 ending physician. as the burial-transit permit. Pages 1, 2, 3 should	œ												
2,	DIRECTOR	RESIDENCE OF DECEDENT	OUTTIAL		OHNE	<u> </u>		PION	I GOMEKI				
L SS	S	10a. STATE 10b. COUNT	TY .	10c. C	TY, TOWN OR LO	CATION			10d. INSIDE CITY				
E	뜻	Manusland No.							LIMITS?				
ij		Maryland Mon	tgomery		ilver S				1 YES 2 NO				
ž.	\¥					101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
nn. Tansi	FUNERAL	11516 Joseph Mill	Road			2090	U	.S.A.					
Sloig ral-tr	5	11. MARITAL STATUS	12. WAS DECEOENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS	OECENDENT OF HISPA	NIC ORIGIN? (Specify Y		RACE — American Indian, Black, White, etc.				
5-0020 nding physic as the burial	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	0 If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, atc. 1 ☐ YES 2 ☐ NO Specify: Specify:								
5-(5 WASHES 1 DIVINES							White				
MARYLAND 2121 retained by the hospital or atti 5 should be detached for use notified at once.	GE	15. DECEDENT'S EOU (Specify only highest grad	JCATION e completed)	16a. DECEDENT	S USUAL OCCUP work done during	ATION	16b. KIND OF B	USINESS/INDUST	TRY				
	ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)	Those or working							
	₽ I	9		Laborer	•		Const	ruction					
	COMPLET	17. FATHER'S NAME (First, Middle, Last)		AME (First, Middle, Maide									
		Arthur Lee Toney				Ronnie	Lee Kerw		3				
	B	19a. INFORMANT'S NAME (Type/Print)		195. MAILIN	G AODRESS (Str		Route Number, City or To		del				
	5	Arthur Lee Toney											
y be		20a. METHOD OF DISPOSITION		111216	Joseph	MILL Roa	d Silver	Spring,	Maryland 20906				
IORE, e 6 may be ector, page		1 ⊠ Buriel 2 ☐ Cremation 3 ⊠ Ren	noval from State 20	 b. PLACE AND DATE metary, crematory or 	OF DISPOSITION other place)	Cemeterv	OATE 20c. L	OCATION — City	or Town, State				
MC Sirect	1	4 Donation 5 Other (Specify)	OATE 20c. L	et,West	Virginia								
BALTIMORE, hours after death. Page 6 may be fin by the funeral director, page or removal. medical examiner must be a	0.00	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAM	E AND ADDRESS OF F	ACILITY						
AL deat fun		100	m 1		Fran	icis J. Co	llins Fund	eral Ho	me, Inc.				
B iffe B	-	22 PART I Enter the discourse or	Marke	your	1300	Universit	y Blvd.,W	Sil.S	pr.,MD 20901				
B nours after d in by the or removal		23. PART I. Enter the diseases, or shock, or heart fellure.	List only one cause on a	a the deeth. Do each line.	not enter the	mode of dying, su	ch se cardiac or rea	piratory arrest.	Approximate interval Between				
filled on, or		IMMEDIATE CAUSE (Fine) Onset and Death											
natio		disease or condition a. Multiple Injuries Due To (on As a consequence of):											
3760 rted within completely ial, cremati		DUE TO (OR AS A CONSEQUENCE OF):											
O. BOX 68760 ertificate be executed within 24 in popysician and completely filler giglene prior to burial, cremation, other traumatic event, the	z												
K 68 executor to bur	CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OF):								
P.O. BOX or certificate be ex nding physician a Hygiene prior to or other traum.	X	cause. Enter UNDERLYING											
O. B. certificate ding physis ygiene pri	F	CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):											
. 0 0 5	E	resulting in death) LAST			•				İ				
T = 0 = 0	9		d										
이 음 후 호 클		PART II. Other aignificent condition	ns contributing to death t	but not reaulting	in the underig	ying cause given in	Part i. 24a. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS				
that the by the and land	EDICAL					201 - 10-11-11	PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
Signed Health a							1\1\1\1\1\1\1\1\1\1\1\1\1\1\1\1\1\1	2 🗌 NO	OF DEATH?				
REC requires been sign shows	2								1 YES 2 NO				
AL RE ne law requ has been bept. of I n 23 sho	PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH Y	ES 🗆 NO	UNCERTAL	N 🔲						
VITAL IAN: The law tificate has lee State Dept	3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE		ne)							
PHYSICIAN: The this certificate h with the State D red, or item	S	1 TYES 2 NO	1 Inputient & EXER/Out	patient 3 DOA	OTHER:	fome 5 - Residence	8 Other (Specily)						
n 9 9 5 1	ξI	27. MANNER OF GEATH	28a. DATE OF INJURY	28b. TH	ME OF 28c.	INJURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED COLLISION				
ION OF NDING PHYS I: After this or r death with Is marked,		1 Natural 5 Pending	(Month, Day, Year)		2 M 1	WORK? ☐ YES 2 ☐ NO	Dr. cen a	- 61	de frait de				
ATTENDING PETTON S after death	BY	2 Accident Investigation 3 Suicide B Could not be	28a. PLACE OF INJURY	1			28f. LOCATION (Street	au	no -urea osia				
TTEN TTEN TOR: after		4 Homicide B Could not be	building, etc. (Spe	GI(V)		THE B	City or Town, State	and Number of h	surei Houte Number,				
DIVISION OR ATTENDING F DIRECTOR: After hours after death item 28 is mar	COMPLET		<i>F</i>	Ladra	u		MIL	eso R	d / Rive Rd				
DIV AL OR / L DIRE 2 hours	립	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	rledge, death occur	red at the time, o	late and place, and due	to the cause(a) and m	nner as stated.					
ERA in 7.	8		ER: On the basis of axaminetic						use(a) and manner as stated,				
TO THE HOSPITAL OF TO THE FUNERAL DE FINE WITHIN 72 HOMEN AND TO THE WITHIN 72 HOMENTANT. IF IN		29b. SIGNATURE AND THILE OF CERTIFIE	to the		Cresco	to the Control of							
물 물을 통	BE	THE OF GENTIFIE	4/0/1			29c. LICENSE NU			GNED (Month, Day, Year)				
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		30. NAME AND ADDRESS OF PERSON WI	/	ATH (ITEM 27) (Type	e, Print)								
		DWIN K FR	mler	111 DEN	IN CTP	FFT DAT	TIMORE	MADVI 7	ND 21201				
15.00		31. DATE FILED (Month, Day, 197)	39 REGISTRAN'S WON		VII			MARKET ALL	1911 ((
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Bernard A. Heckman,

APR 19 1995

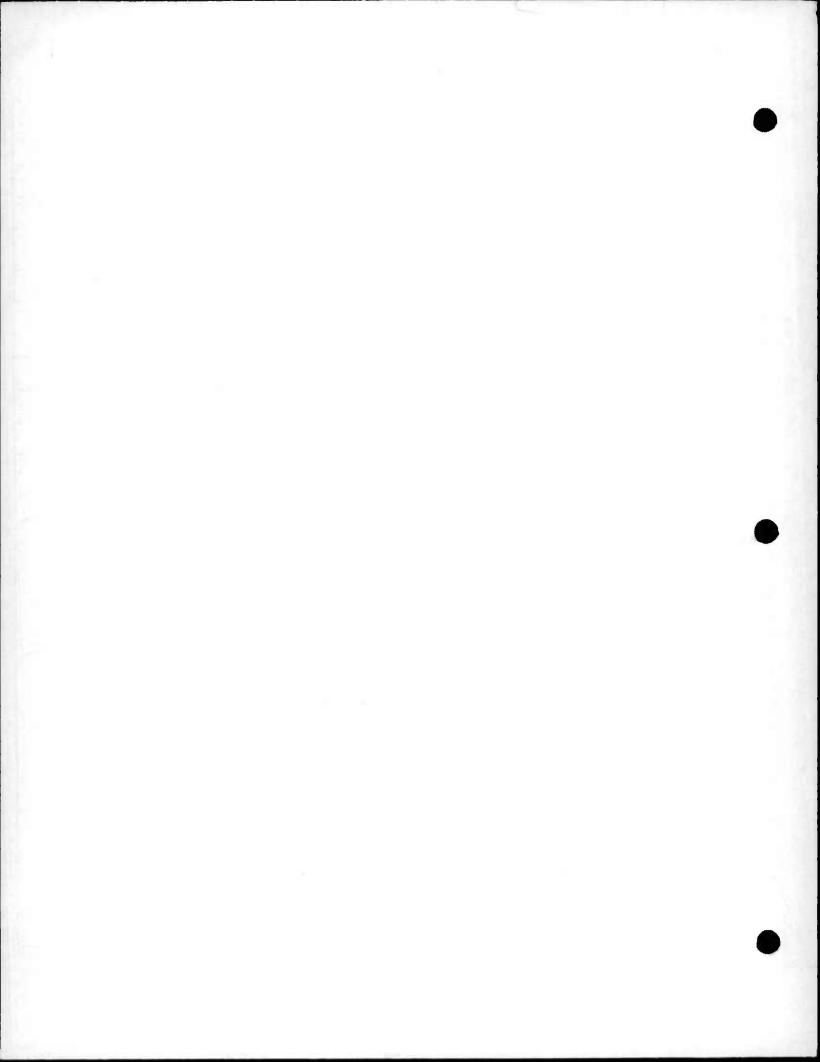
31. DATE FILEO (Month, Day, Year)

M.D.

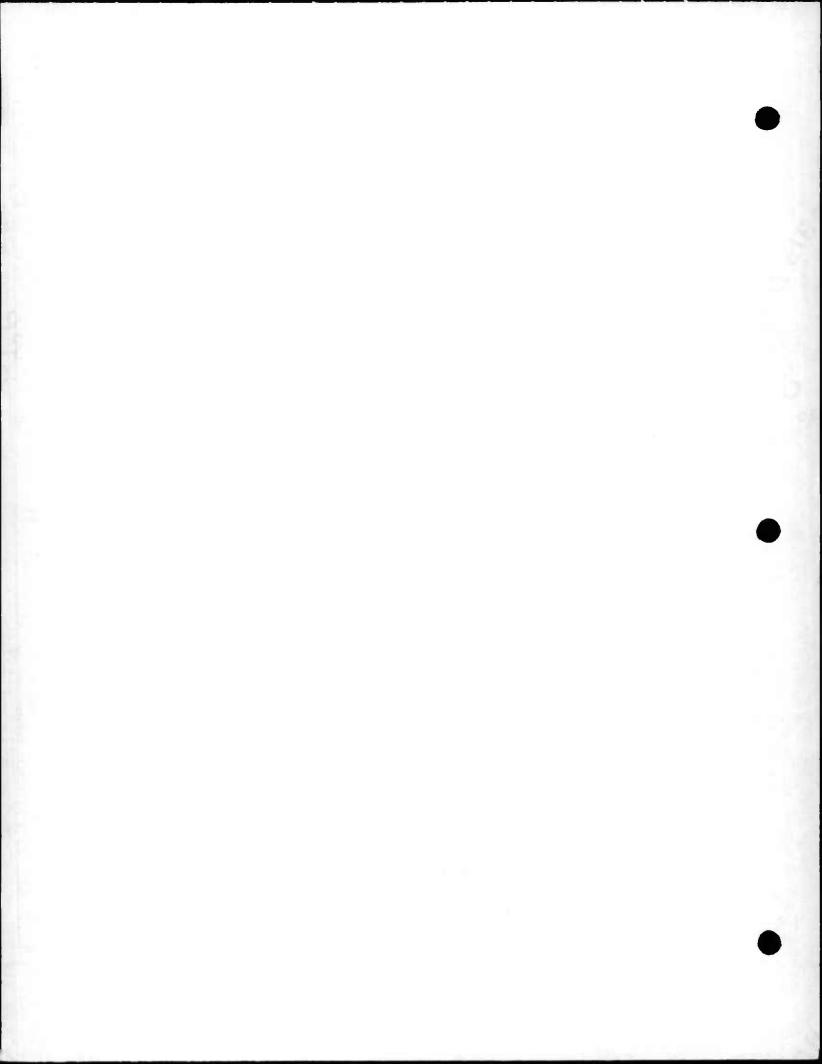
32. BEGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Evelyn Thrift Fritts April 17, 3:36 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 577-09-7559 1 M 2 X F 90 Dec. 21, 1904 Iowa Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 303 Hillmoor Drive Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery permit. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 303 Hillmoor Drive 20901 USA funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
 The YES 2 X NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: White 3 🕅 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Dental Assistant Dental 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Ħ William T. Fritts Mary Katherine Printz BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ann T. Malpass 10214 Big Rock Road Silver Spring, Maryland 20901 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Burial 2 Cremation 3 Removal from State Gibeon Baptist Church Cem. 4/19/95 Village, Virginia Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil.Spr. MD 20901 the medical 23. PART I. Enter the disesses, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory screet, filled in by shock, or heart failure. List only one cause on each line 6 Interval Between IMMEDIATE CAUSE (Final Onset and Death the cremation. disease or condition resulting in death) Carcnema. been signed by the attending physician and completely of. of Health and Mental Hygiene prior to burial, crematic Pancieatic 8 MOO. event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate 8 cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significent conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? that any General a. 1 YES 2 NO requires shows : not contributed to by Tobacco - Hecomon, HD. 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES EN NO has b. Dept. UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one, certificate h Item EXAMINER? HOSPITAL: 1 YES 2 NO 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. OEŞCRIBE NOW INJURY OCCURED this c marked 1 Netural 5 Pending 1 YES 2 NO BY After 1 Investigation 2 Accident ATTENDING 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be DIRECTOR: / COMPLETED 28 4 Homicide determined tem 8 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL Within 72 P = TO THE HOSPITA
TO THE FUNERAL
BE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Benoud a. Helpman, N.D. 4/18/95 Do 5373 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8830 Cameron Street #405 Silver Spring, MD. 20910-4114



		1 - STATE REGISTRAR	STATE OF MARY	AND / DEPART	MENT OF H	IEALTH AND I	MENTAL HYG					
		1. DECEDENT'S NAME (First, Middle, Linst)					2. DATE OF DEAT	DAY	YEAR 3. 1	TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER	1		aylor		April 17	, 1995	5	:05 P		
Pja		462-10-7922	1 □ M 2 🔀 F 🧧	32 YRS.	IF UNDER 1 YEAR IONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea March 6	, 1913	Texa			
. 2, 3 should	DIRECTOR	9a. FACILITY NAME (If not inetitution, give Manor Care Bethe	THE PARTY OF THE P		Chevy	Chase	EATH		tgome			
Pages 1,	EC.	10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCAT	TION			10d	I. INSIDE CITY		
permit. Pa		Maryland Monto	jomery	Silv	er Spri	.ng		100 CITIZI	1 EN OF WHAT	YES 2 X NO		
. usit	ER/	8214 Cedar Street	-			20910		,	ted S			
1215-0020 r attending physician. use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1	12. WAS DECEDENT EVER FORCES? 1 YES					NIC ORIGIN? (Specify Yes or No— 14. RACE — Black, N				
ttendi	E	15. DECEDENT'S EDU	CATION	16e. DECEDENT'S U	SUAL OCCUPATION	DN .	16b, KIND OF	F BUSINESS/INDU		ite		
N E	1	(Specify only highest grade Elementary/Secondary (8-12)	College (1-4 or 5+)	(Give kind of wo life. Do NOT use	rk done during mo	at of working			• • • • • • • • • • • • • • • • • • • •			
AND the hospital detached fo	once.	CT FATURE OF MANY CO. A AND A CO.	4	Librar	ian			of the	Army			
YLA by the		17. FATHER'S NAME (First, Middle, Last) Reuben Albion	Taylor			Mabel	ME (First, Middle, Me					
MARYLAND retained by the hospits should be detached	2 8	19a. INFORMANT'S NAME (Type/Print)	Tayror	19b. MAILING A	DORESS (Street a	nd Number or Rurel F		Dennis	Code)			
. 2 8	TO TO	Albion D. Taylor		Same a								
may X. pa	must b	20a. METHOD OF DISPOSITION 1/☐ Burlal 2 ☐ Cremation 3 ☐ Ram	oval from Stata CO	b. PLACE AND DATE OF	r place)	me of		c. LOCATION — CI				
Page 6 ma	- Je	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIE		Nevada Cer	_	ID ADDRESS OF FAC		Nevada,	Texa	S		
ALT Seath.	examiner	> Decen	/ / R	2 20 -	Rapp	Funeral	Services					
after of the moval.		23. PART i. Enter the diseeses, or	complications that cause	d the death. Do no	enter the mo	ist Aven	ue, Silv	er Spri	ng, M			
filled in on, or re	medical	shock, or heert fallure. IMMEDIATE CAUSE (Final	List only one ceuse on e	ech line.	. onto the mo	ao or aying, sao.	TES COIGIOC OF I	ospiratory arre	pt,	Approximate interval Betwee Onset and Deat		
× =	t, the	disease or condition resulting in death)	Alzheimers	Disease					i	8 Yrs		
ompletel	event,		DUE TO (OR AS	A CONSEQUENCE OF):								
executed and control to burial,	CATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR AS	A CONSEQUENCE OF):								
ate be sysiciar prior	. 0	cause. Enter UNDERLYING CAUSE (Disesse or injury	Enter UNDERLYING (Disesse or Injury									
certificate ding physi	y, or other	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):								
DS, P. ne death the attend Mental H	CEH OF		d		·							
at the by the and Me	AL CE	PART II. Other eignificent condition				ceuse given in	Part I. 24a. WAS	S AN AUTOPSY RFORMED?		E AUTOPSY FINDINGS		
	MEDICAL	Multiple infarct	disease, H	ypertensı	on		1 D YE	S 2 X NO	COM	IPLETION OF CAUSE DEATH?		
C of pe 7		DID TOBACCO USE CONT	RIBLITE TO CALISE O	OF DEATH YES		LINICEDTAIN			1 🗆	YES 2 X NO		
VIIAL AN: The law inficate has b	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH	(Check only one)	ONCERIAIN						
VIIAN: The rtificate one State	or ite	1 VES 2 X NO	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 DOA 4	THER: Nursing Home	5 Residence	8 Other (Specify)					
PHYSIC This ce	marked, BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	JRY AT RK? ES 2 NO	28d. DESCRIBE HO	OW INJURY OCCU	RED			
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate in hours after death with the State C	28 Is	2 Accident Investigation 3 Suicide 8 Could not be detarmined	26a. PLACE OF INJURY building, etc. (Spe	r — At home, larm, stre	et, factory, office		281. LOCATION (Sti City or Town, S	reet and Number or State)	Rural Route	Number,		
L DIRECT POURS	PLE.	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	ledge, death occurred	at the time, data	and place, and dua	to the cause(a) and	manner as stated				
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho	NO N	2 MEDICAL EXAMINE	R: On the besis of examination	n and/or investigation,	In my opinion, de	eath occured at the t	time, data and place	e, and dua to the	cause(s) and	manner as stated.		
프로 등 등 등	PORT	296. SIGNATURE AND TITLE OF CERTIFIES	200/00	2001		29c. LICENSE NUM	BER			th, Day, Year)		
223	₹ P	30. NAME AND ADDRESS OF PERSON WAT	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pr	int)	D39456		Apr	il 17	, 1995		
		lila T McConnel		530 Wisco		e, Chevy	Chase,	MD 208	15			
		APR 19 1995	Julia Davilso									

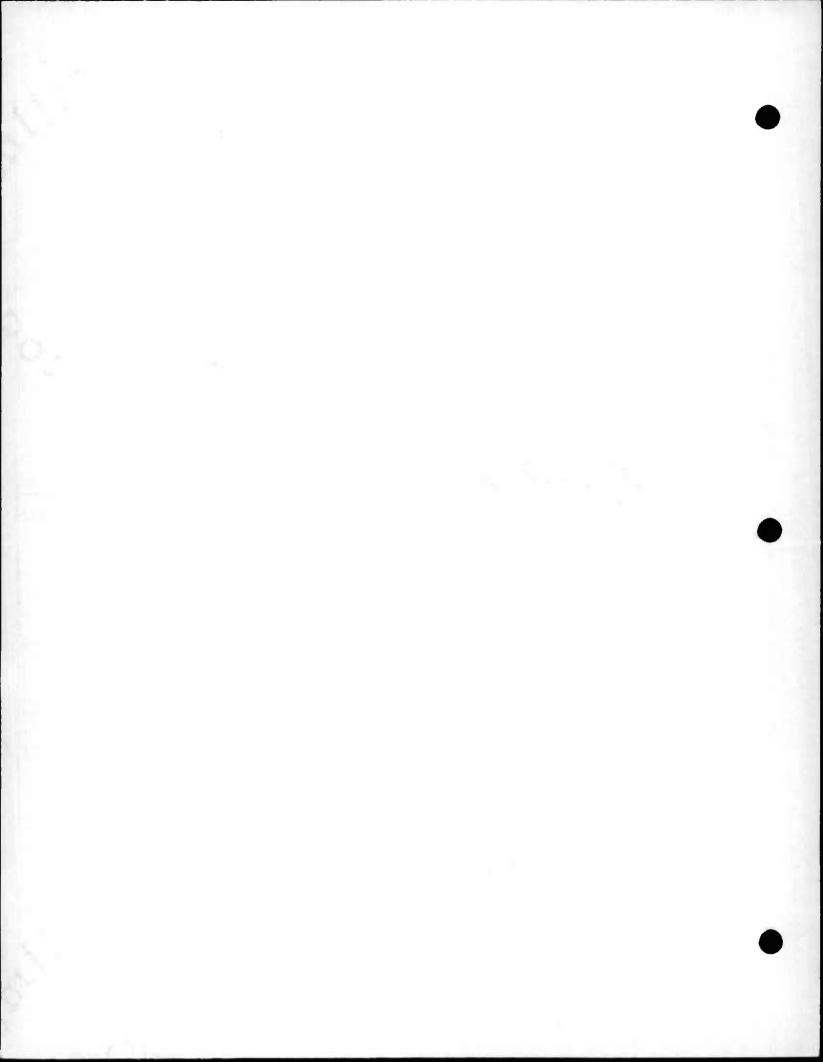


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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AN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attendi	y th
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SPITAL OR ATTENDING PHYSICIAN: Th	VERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI	RTMENT OF	HEALTH AND								
	1. DECEDENT'S NAME (First, Middle, Last)		OLIVIII	TOATE OF	DEATH	REG. NO	'	3. TIME OF DEAT	PM .				
	Gordon			MONTH D		EAR	М						
	4. SOCIAL SECURITY NUMBER		orrey In yrs. lest birthday)	IF UNDER 1 YEAR		March 2			J M				
	541-22-4375	1	75 vrs.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1.	BIRTHPLACE (State or Fo.	preign				
			J THS.			12/4/19	19	Oregon					
~	9e. FACILITY NAME (If not institution, give				OR LOCATION OF D	EATH		OF OEATH					
Ö	Shady Grove H	ospital		Rock.	ville		Mont	gomery					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	~	I in an										
<u>=</u>		tgomery	gomery Gaithers					10d. INSIDE CITY LIMITS?	,				
		cgomery	Ga					1 TYES 2 T	NO				
FUNERAL	10e. STREET AND NUMBER				Of. ZIP CODE			N OF WHAT COUNTRY?					
Ä	392 Russell Av	enue			20877			USA					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or No— 14	. RACE — American India	nn,				
BY F	1 Never Married 2 XMarried	FORCES? 1 YES			pecify Cuban, Mexico S 2 XNO Specia	en, Puerio Rican, atc.)		Black, White, etc. Specify: T.TTT TO DIAM					
	3 Wildowed 4 Divorced				21			WHITE	G				
Ш	15. DECEDENT'S EDU (Specify only highest grade	ICATION completed)	16a. DECEDENT'S	Work done during m	ION	16b. KIND OF BU	SINESS/INDUS	TRY					
ių.	Elementary/Secondary (0-12)	College (1-4 or 5+)	me. Do NOT u	se retired.)	ost or working								
AP.		5+	Anayl	SIS			CIA		100				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	AME (First, Middle, Malden	Surname)								
	Raymond Torre	ey			Minn								
BE	19a. INFORMANT'S NAME (Type/Print)		195 MAILING	Anness /Street				4-1	_				
2	Ann Inbseth To	orrev	392	Russel	DDRESS (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) USSell Avenue, Gaithersburg, MD. 20877								
	20e. METHOD OF DISPOSITION												
	1 Burial 2 Cremation 3 Rem	novel from State 20b.	PLACE AND DATE	OF DISPOSITION (N the cplace) 17	lame of	DATE 20c. LO	CATION — Cit	y or Town, Stata					
	4 Donation 5 Other (Specify)		orgeto	wn Med	. Schoo	13/28/95	wasn.	ington, D	.C.				
	21, SIGNATURE OF FUNERAL SERVICE LI	CENSEE		AUS	ND. ADDRESS OF FA	ster Fune	eral I	Home					
		1//		360	5 14th	Street 1	I W E	Wash, DC20	010				
	23. PART I. Enter the diseases, or	complications that caused	the death Do						_				
	shock, or heart fellure.	List only one cause on ea	ich line.	not enter the me	ode or dying, suc	n as cerdiec or reep	iratory srres	Approxima					
	IMMEDIATE CAUSE (Finel	Navarca	roagt	ion +0				Onset and	Death				
	disesse or condition resulting in deeth)	Adverse	react	TOIL CO	mearca	tion		Days					
		DUE TO (OR AS A CONSEQUENCE OF):											
Z		Chronic	Depr	ession	ion Days								
2	Sequentially list conditions, if eny, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):									
S	csuse. Enter UNDERLYING	C.											
CERTIFICATION	CAUSE (Disease or Injury that Initieted events	DUE TO (OR AS A	CONSEQUENCE O	F):									
F	resulting in deeth) LAST	4											
2													
A	PART II. Other significent condition	as contributing to deeth bu	t not resulting	in the underlyin	g ceuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FIN					
일	Dehydration a	and malnutr	ition a	associa	ated wi	th PERFOR		AVAILABLE PRIOR T					
MEDICAL	ileostomy for	inflammat	ory boy	wel dis	sease.		OTHO	OF DEATH?					
								1 🗌 YES 2 🗌 N	ю				
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL					NLI							
ত	EXAMINER?	HOSPITAL:	6. PLACE OF DEA	OTHER:									
YS	1 TES 2X NO	1 Xinpatiant 2 - ER/Outpe	itlant 3 DOA		na 5 🗆 Realdenca	6 Other (Specify)							
표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM		JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCUP	ED					
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO								
	3 Suicide 6 Could not be	28a. PLACE OF INJURY	At home, ferm,	street, factory, offic	e	281. LOCATION (Street)	and Number or	Rural Route Number,					
III I	4 Homicide detarmined	building, etc. (Speci	17)			City or Town, State)			[
4	29a. CERTIFIER . X CERTIFICATION OF THE PARTY OF THE PART	000											
COMPLET	(Check only 1 23 CERTIFYING PHYSI	CIAN: To the best of my knowle	idge, death occurre	ed at the time, data	and place, end due	to the cause(e) end mer	mer as stated.						
ġ l	2 MEDICAL EXAMINE	R: On the beals of examination	and/or investigation	n, in my opinion, c	death occured at the	time, data and placa, an	d due to the c	euse(a) and manner as ats	sted.				
\sim	29b. SIGNATURE AND TITLE OF CERTIFIE	R		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ye				$\overline{}$					
ш					SAC FICENSE MAIL	WOER	29d. DATE SI	GNED (Month, Dav. Year)					
O BE COMPLETED BY PHYSICIAN:		ion had.			D-19			GNED (Month, Day, Year) Ch 28,19	95				



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31. DATE FILED (Month, Day, Year)

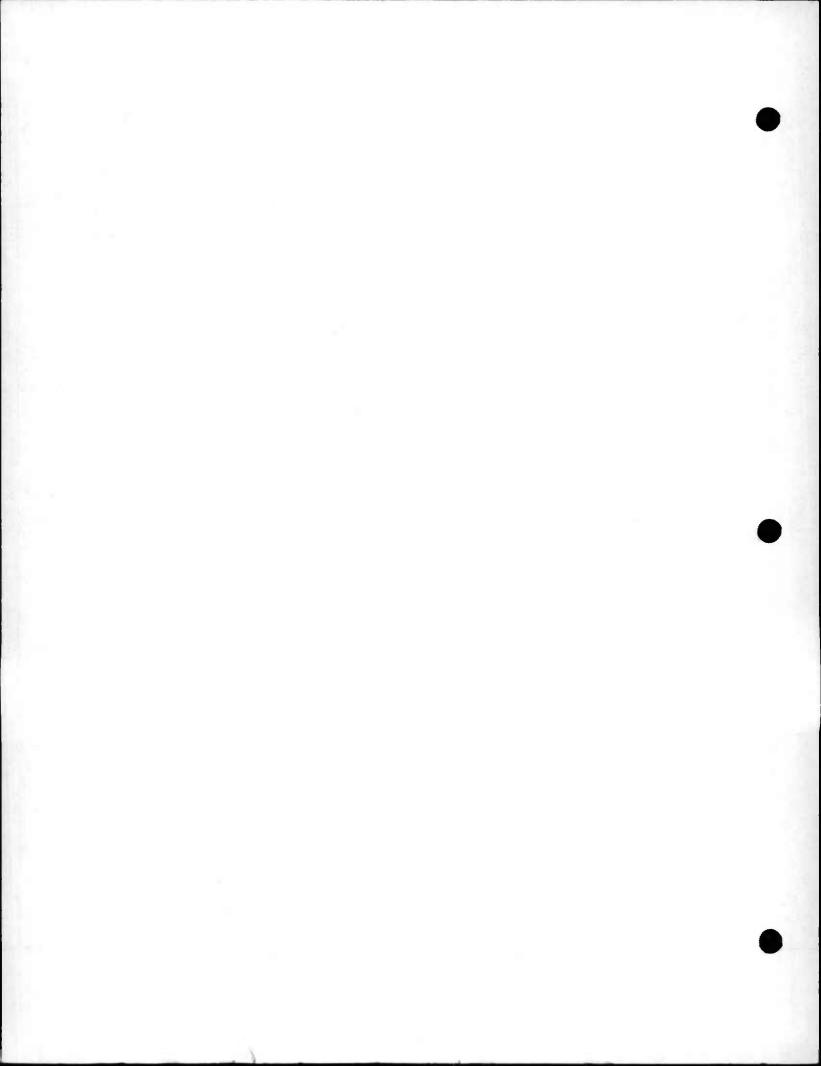
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32. REGISTRAR'S SIGNATURE Davidson Reveall

use as the burial-transit permit. Pages 1, 2, 3 should

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AL RECORDS, P.O. BOX 68760	certificate
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Marie TRANTOW April 13. 1995 6:45 P. 4. SOCIAL SECURITY NUMBER B. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 🔯 F 326-26-3865 60 July 15, 1934 Illinois 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 8111 Needwood Road Apt.# T 102 Derwood Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Montgomery Derwood 1 YES 2 X NO FUNERAL 10a STREET AND MIMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8111 Needwood Road Apt.# T 102 20855 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 14. RACE --- American Indian, Black, White, etc. 1 Never Merried 2 X Married If yes, specify Cuben, Maxican, Pu 1 ☐ YES 2 🏋 NO Specify: В Specify. 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) 4 Home Maker Own Home Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 70 Salvatore **Blando** BE Josephine Restivo notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donald J. Trantow 8111 Needwood Rd. Apt. # T 102, Derwood, MD 20855 pe 20a, METHOD OF DISPOSITION
1 № Burlel 2 □ Cremation 3 № Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION - City or Town, State DATE must Andersonville Nat. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4/17 Andersonville, Georgia examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSUE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart taljure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (FIRST Onset and Death the disease or condition Metastatic Breast Cancer event, resulting in death) 6 years DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): It any, lasding to immediata cause. Entar UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE any 1 YES 2 X NO OF DEATH? shows a 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [] NO [X] 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Oulpatient 3 | DOA OTHER: 1 YES 2 X NO 10 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED L DIRECTOR: After this ce hours after death with the litem 28 is marked, marked, 1 X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, streel, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER
(Chack onto 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D BE filed within 72 ho 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and menner ee stated. 296. PIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MAG D40854 April 14, 1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Riseberg, M.D. 10/12N226 NCI, 9000 Rockville Pike, Bethesda, MD 20892



Russia

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 X YES 2 NO

White

Approximate

24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

Interval Between

Onset and Deeth

8. BIRTHPLACE (State or Foreign

9:20

рм

2. DATE OF DEATH

April 16,

DAY

1995

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day, Year)

18 1995

1. DECEDENT'S NAME (First, Middle, Last)

Anna Anastasia Taylor

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RECORDS,	
OF VITAL	
DIVISION	

IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS 345-01-3392 1 🗌 M 2 💢 F 87 YRS. Sept. 4, 1907 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 310 Summit Hall Road Gaithersburg Montgomery RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION Maryland Montgomery Gaithersburg permit. 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit 310 Summit Hall Road 20877 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Merried 2 Merried BY 1 YES 2 X NO Specify. 3 🕅 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPI 8 Housewife Own Home notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) William Janakauskas Sally Vaitkus BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lana Cerny 310 Summit Hall Road, Gaithersburg, MD 20877 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must DATE 1 💢 Buriel 2 □ Cremetion 3 🔯 Removal from State 4 Donation 5 Other (Specify) Memorial Park St. Petersburg, Florida examiner 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 10 East Deer Park Drive vekal Gaithersburg, MD 20877 in and completely filled in by the to burial, cremation, or removal. the medical 23. PART I, Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart fellure. List pnly pna cause on eech line IMMEDIATE CAUSE (Fine) cardenoma - manalible diseese or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) event, executed traumatic CERTIFICATION Sequentielly list conditione. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician I Mental Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE DF) that initiated events resulting in death) LAST 0 injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY has been signed by t Dept. of Health and PERFORMED? that shows any 1 🗌 YES 2 🙀 NO requires DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN X PHYSICIAN: 23 OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) TO THE HOSPITAL OR ATTENDING PHYSICIAN: The TO THE FUNERAL DIRECTOR: After this certificate to fied within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Item HOSPITAL OTHER: 1 - YES 2 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 X Residence 8 Other (Specify) marked, or 27 MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Naturel 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, Cify or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 🛣 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner ee atated (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 43 2 SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15225 Shady Grove Road#105, Rockville, MD 20850-3283 Pasqual Perrino

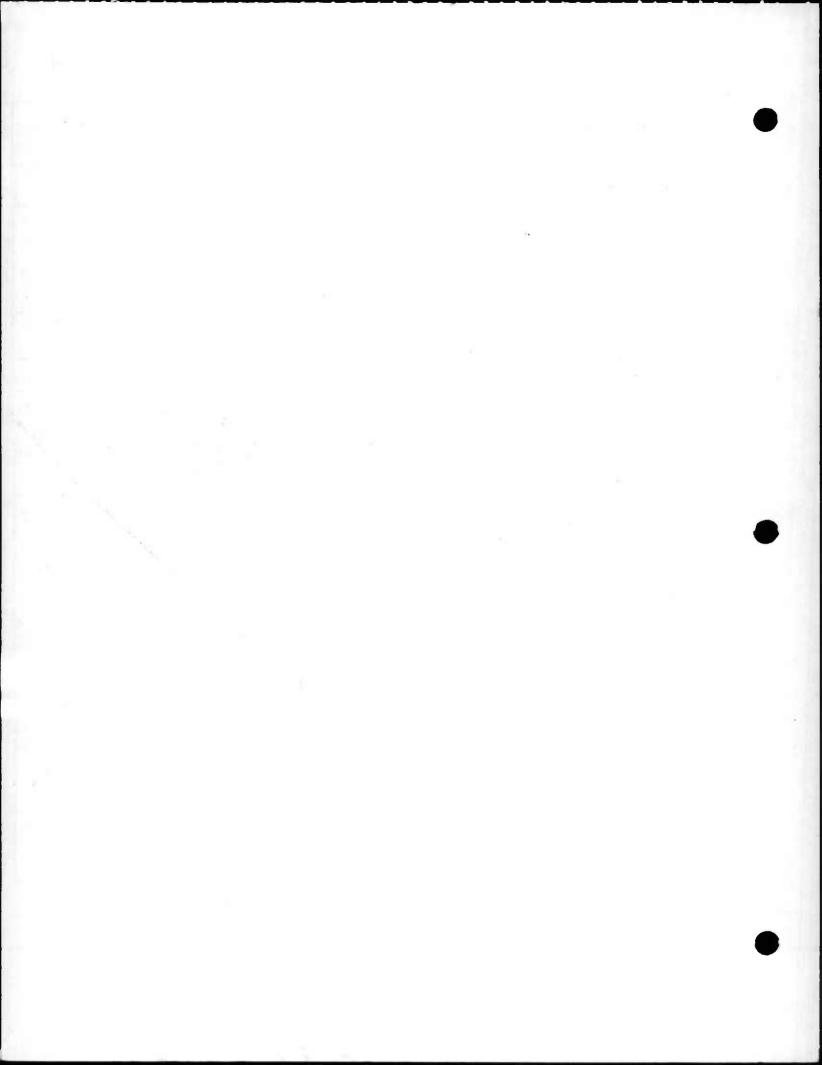
32 REGISTRAR'S SIGNATURE

Julia Davolson Rendall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

6. AGE (In vrs. last birthday





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	I Hygiene prior to burial, cremation, or removal,	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dea	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the at	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 Is marked, or item 23 shows any Injury,

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF OEATN A														
		MADV	LOUISE	THENT IEST						MONTH DAY YEAR					
	4. SOCIAL SECURITY NUMBER	MAKY BER	LOUISE 5. SEX	6. AGE (In yrs. las	et hirthrime)	IE (MIDE)	I 1 YEAR	IF UNDER	244 1820		APR 12 1995 4:05				
	579-26-0141		1 M 2 X F	68	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Year)		8. BIRTHPLACE (State or Country)		
					THO.			1,120			Jan. 31, 1927 Ohio				
~	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	r, town (OR LOCATI	ON OF DE	EATH		9c. COL	INTY OF D	EATN	
0	NATIONAL N	ENTER			BE	THESI	DΑ				MON	TGOMERY			
<u></u> [RESIDENCE OF DEC		T 100 CIT	Y, TOWN	00 1 004	TON!									
DIRECTOR	Maryland					ION						10d. tNSIOE CITY LIMITS?			
91	10e. STREET AND NUMBER	Montgo	Jille Ly		MII	eato								₩ YES 2 NO	
RA				101	. ZIP COD						HAT COUNTRY?				
ᄬᅵ	11802 Huggi	ns Dri						2090					JSA		
5	11. MARITAL STATUS 1 Never Married 2 X	T EVER IN U.S. AR		13.	WAS DEC	ENOENT (OF NISPAN	NIC ORIGI	N? (Specify Yes	or No-	14. RACE Black	American Indian, White, atc.			
BY FUNERAL	3 Widowed 4 Dive		IF YES, GIVE W	WAR OR OATES				2 🔯 NO			, , , , ,		Specif	White	
	15 DEC	EDENT'S EDUC	CATION	tto DE	CEDENTIO	HOUAL	00110171							wnite	
COMPLETED	(Specify onl	y highest grade	completed)	(G	CEDENT'S two kind of Do NOT us	work done	during ma		ng	161	b. KINO OF BU	SINESS/IN	DUSTRY		
اچ	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Secre						17-14	ter E	1		
Σ	17. FATNER'S NAME (First, M	Heleffe A = +43			ecre	tary							teea		
	Harry Alan										Middle, Maiden	Surname)			
H	19a. INFORMANT'S NAME (ers						_		√hite_				
2	7.00	,,									ber, City or Tow				
	Brenda Tenl								re, h	vheat	ton, Ma	_			
i	20a. METNOD OF OISPOSIT 1 N Burlet 2 ☐ Cremetic	n 3 🗆 Rame	oval from State	Qemetery, cre	MANO OATE	of DISPOS	SITION (Na	me of		OAT	E 20c. LO	CATION —	City or To	wn, State	
	4 Donation 5 Other			Arlin	gtón	Nat:	iona.	L Cer	mete:	ry 4/	18 Arli	ingto	ton, Virginia		
i i	21. SIGNATURE OF FUNERA	L SERVICE LIG	ENSEE	1 . 2		22.	NAME AN	D AOORE	SS OF FA	CILITYH	ines-R	inal	di Fu	neral Home	
	Tani	1/10	DAX +1	Olla	nck	Si	louu Tvei	New Spr	Hamp ino	OSD1: Ma:	re Ave ryland	nue 209	204		
	23. PART i. Enter the di	seases, or o	complications the	t caused the de	ath. Do									Approximate	
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death														
	IMMEDIATE CAUSE (Fir disease or condition														
H	resulting in death)				RUCT	IVE	LUNC	DIS	SEASE			15 years			
_ 1	DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):														
AT	if any, leading to imme- cause. Enter UNDERLY	NG			3 A CONSCIOLACE OF J.							j .			
윤	CAUSE (Disease or Injuthat initiated eventa	ry S	OUE TO	(OR AS A CONSEC	DUENCE O	f):									
E	reaulting in death) LAS	т 📗													
씽															
MEDICAL	PART ii. Other algnifica	nt condition	a contributing to	death but not r	esulting	in the u	nderlying	cause (given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
8								1 TYES 2			COMPLETION DF CAUSE DF DEATN?				
													- 1	1 NES 2 NO	
_ "	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	SΠ	NO [LUNC	ERTAIN	<u> </u>					
PHYSICIAN:	25. WAS CASE REFERRED TO				E OF DEA	_									
SIC	EXAMINER?		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE!		5 □ B	sidence	s □ Oth	er (Specify)				
主	27. MANNER OF OEATH		26a. DATE OF		28b. TIM	E OF	28c. INJ	URY AT			SCRIBE HOW I	NJURY OC	CURED		
		Pending Investigation	(Month, D.	ay, Year)	INJ	URY M		RK? 'ES 2 [NO						
ĕ I	2 - 6	Could not be	26s. PLACE O	F INJURY — At ho	ma, farm,	treet, fac	tory, office			28f. LOC	CATION (Street a	and Numbe	r or Rumi R	oute Number	
Ë		detarmined	building,	atc. (Specify)							or Town, State)				
9	29a. CERTIFIER X	TEVINO DILVO	MANAGE TO A STATE OF THE STATE												
COMPLETED	(Check only	CAL EYAMINE	CIAN: To the best of	my knowledge, de	ath occurs	od at the t	ime, data	and place	, and dua	to the ca	use(s) and mar	iner aa sta	ted,		
One) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the									ne cause(a)	and manner as stated.					
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER							ENSE NUM					(Month, Day, Year)	
5	Ju	- M4	· .					01	01-0)5007	77 (VA)	14	-12	-25	
- [30. NAME AND AODRESS OF			SE OF DEATH (ITE	М 27) (Туре	Print)		NT A IT	TORTA	T NTA	TTAT NOT	ZDT C	I OF	MARIED	
		T ID						A A	平书 角铁	1 N	VAL ₈ 8	4 D 4 C 6	H CE	NIEK	
1	NORMAN LEE	LI,	MC, USNR					DET	UEST	7.11	20003	7 -200	10		
	31, DATE FILED (Month, Day,	Year)		R'S SIGNATURE				DEI	HESL	A PIL	20003	3-300	0		
		Year)	32. REGISTRA	R'S SIGNATURE				DEI	HESL	A FIL	2000	9-300	0		

BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page 5 should be detached for use as the burial-transit perm	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	CONDUCTOR AND ANALYSIS OF TAXABLE ANALYSIS OF TAXABLE ANALYSIS OF TAXABLE ANALYSIS OF TAXABLE ANALYSIS OF TAXABLE ANALYSIS OF
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95 13887 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEMENT'S NAME (First, Middle, 2. DATE OF DEATH 3. TIME OF DEATH 27A APR 4. SOCIAL SECURITY NUMBER S SEY IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH 1 M 2 0 HOURS 714-18-1267 YRS 70 May 29. Indiana 9e. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Potomac Montgomery 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11615 Greenlane Drive 20854 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried BY Specify: 3 Widowed 4 Divorced World War I White ETED. 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 2 Comptroller Insurance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) notified at Elmer Toney BE Vera Conn 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Garner Toney 11615 Greenlane Drive, Potomac, Maryland 20854 pe 20e. METHOD OF DISPOSITION
1 M Burial 2 Cremetion 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) April 18, 1995

Gate of Heaven Cemetery 20c. LOCATION - City or Town, State **Hust** 4 Donation 5 Other (Specify) Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACULTY
ROBERT A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery
Avenue, Rockville, Maryland 20850-2805 M00831 Rusence Jarbara 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List pniv one cause on each line interval Between IMMEDIATE CAUSE (Finel Onset and Death 2 disease or condition resulting in death) 1 teriosclero ears DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION OF CAUSE 1 YES 2 X NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA TYES 2 NO OTHER: 4 - Nursing Home S - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural м BΥ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner se stated 296. SIGNATURE AND TITLE OF CONTIFIER

29c. LICENSE NUMBER

WISCOM

8218

ber 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Jalin Davidson Revolate **APR** 1995

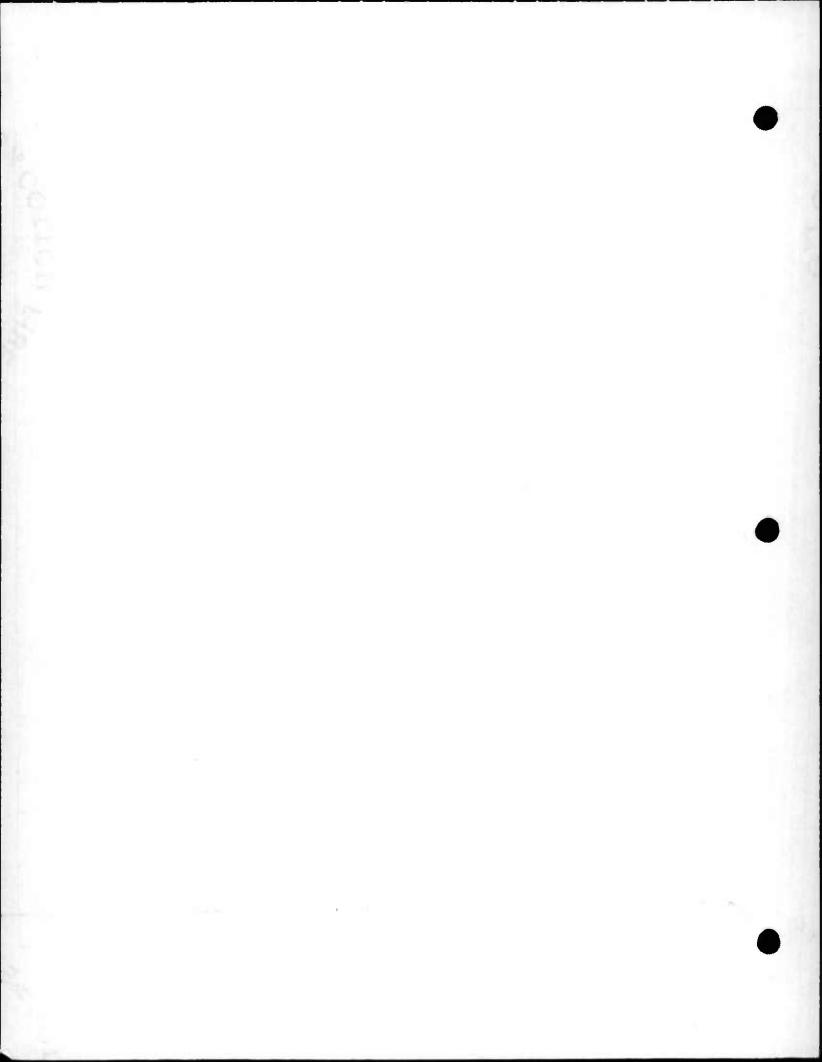
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29d. DATE SIGNED (Month, Day, Year)

Aue



ITEMS: 23 PART I. 27. PER MED ETIM 6-724 6/5/95 + +

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

	1. DECEDENT'S NAME (First, Middle, Lest) AKA Geneva M. Tippett 2. Date of Death 3. Time of Death									REG. NO			2 TIME OF BEATH
	GENEVA		M AR				TIPPETT					95	10:01
	4. SOCIAL SECURITY N	UMBER	5. SEX	_	yrs. last birthday)			IF UNDER 24	\rightarrow	7. DATE OF BIRTH	-		HPLACE (State or Fore
	217-28-	7998	1 M 2 XF		YRS.	MONTHS	DAYS		MIN.	(Month Day Year)	930	Mar	yland
	Se. FACILITY NAME (# /	ot institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH					INTY OF I		
OR	ST.MARYS		TAL			LEONARDTOWN					ST	. MA F	RYS
DIRECTOR	RESIDENCE OF D	10b. COUNT	~										
E	Maryland	1000	Mary's			CITY, TOWN OR LOCATION Charlotte Hall 10d, INSIDE CT					10d. INSIDE CITY LIMITS?		
	10a. STREET AND NUM		riary s			Charle	_	ZIP CODE	Τ		40 000		1 TYES 2 X N
FUNERAL	Rt. 1 Box.	195					1		622		iog. Cit	US	WHAT COUNTRY?
N	11. MARITAL STATUS		12. WAS DECEDEN	YT EVER IN U	J.S. ARMED	13. W	S DEC			C ORIGIN? (Specify Ve	or No.		
	1 Never Married 2		FORCES? 1	YES	2 XNO	H :	yes, spe	ecify Cuban, 25 NO	Mexican	Puerto Rican, stc.)	01 NO-		E — American Indien k, White, etc.
ВУ	3 Widowed 4 🔀	Divorced					1 E3	ZX NO	ършсну:			Spec Wh:	ite
ETED	15. (Specify	DECEDENT'S EDU	CATION completed)	1	6a. DECEDENT'S	Work done du	UPATIO	ON st of working		16b. KIND OF BU	SINESS/IN	DUSTRY	
	Elementary/Secondar	ry (0-12)	College (1-4 or 5	+)		work done du		ar ar morrorg		-			
COMP		8			Housew	ite				Home			
_	17. FATHER'S NAME (First							l		AME (First, Middle, Maiden Surname)			
H .	William He		well		1					M. Boswe			
9	Jane A. Ra									oute Number, City or Tow			111
	20s. METHOD OF DISPO		DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of Town, State										
	1 St Burtal 2 Crem 4 Donation 5 0	ation 3 D Rem	oval from State	cemet	any cramatony or	other place!							
	21. SIGNATURE OF FUN		WHEE -	1	TILLLY			D ADDRESS		4-29 Wal	dort	, MD	20001
	1	worth	Mad	1									
	HOD.		6.4.5	400	2000	Hur	ntt	Funer	ral	Home			
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32, REGISTRAR'S SIGNATURE

1 - FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	REGISTRAR		CI	ERITE	CATE	OF DEA	TH	REG. NO.			
		1. DECEOENT'S NAME (First, Middle, Last) Barbara Ellen TA	YLOR	11.7					2. DATE OF DEATH DA April 24,		YEAR	3. TIME OF DEATH 10:00 α. Μ
		4. SOCIAL SECURITY NUMBER	5. SEX 8.	AGE (In yrs. las	t hirthday)	IF UNDER 1 YE	40 = 1000	R 24 HRS.	7. DATE OF BIRTH	199		
		168-36-9022	1 M 2 F	45		WONTHS DA			(Month, Day, Year)	1950	Countr	PLACE (State or Foreign v) nnsylvania
1		9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TO	WN OR LOCATI	ON OF DE	ATH	9c. COU	NTY OF O	EATH
	DIRECTOR	201 East Avenue				H	agerst	own		W	ashi	ngton
- 1 8	고 기	10e. STATE 10b. COUNT	Υ		10c CITY	TOWN OR L	CATION					10d. INSIDE CITY
			ington		-	gerst						LIMITS?
;	4	10e. STREET AND NUMBER					10f. ZIP COD	E		10g. CITI	ZEN OF W	VHAT COUNTRY?
1	FUNERAL	201 East Avenue	77.7				2	1740			USA	
	₹Ι	11. MARITAL STATUS	12. WAS DECEOENT E FORCES? 1			13. WAS	DECENOENT (OF HISPAN	IC ORIGIN? (Specify Yea	or No	14. RACE	- American Indian, t, White, etc.
2	ā	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR		.0		YES 2 A NO		i, Puerto Rican, atc.)		Speci	
1 5	3	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gi	ive kind of wo	SUAL OCCUP	PATION g most of working	ng	16b. KINO OF BUS	SINESS/IND	USTRY	
3	COMPLEI	Elementary/Secondary (0-12)	College (1-4 or 5+)	0.00	house				her own	homo		
nce.	S	17. FATHER'S NAME (First, Middle, Last)			nouse	WIIC	16. MOT	HER'S NA	ME (First, Middle, Malden			
ed at o	u l	Owen Clarence Me	yers						uth Reeder	,		
office C		19a. INFORMANT'S NAME (Type/Print)		190					oute Number, City or Town			
2 6	-	Jesse Taylor						enue	, Hagersto			
examiner must be notified at once.		20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State	cametery, cre	matory of other	er place)	Metery			CATION -		wn, State g, Maryland
192		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Dere	CISDU				ELTY LE	iter	Sbur	g, Maryland
exami		22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md.21740										
		23. PART i. Enter the diseases, or	complications that or	wood the de	oth Do oo	413	E. WI	TSOIL	biva., Ha	gers	cown	
medica	1	snock, or neart failure.	List only one ceuse	on each line	ain. Do no	t enter the	mode or dy	ing, such	as cerdiac or reapi	ratory arr	eat,	Approximate Interval Between
2	- 1	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. COVUMAN OCCUSSION DUE TO (OR AS A CONSEQUENCE OF): A THOUSE LEW THE CONDITIONS D. A THO										
event, the	H	reaulting in death)	a. DUE TO (OF	AS A CONSEC	DUENCE OF	0611	0>/60					Salden
5 Z	2		A. 1	thous	o lev-	Rec	dono	رعم				
ws any injury, or other traumatic	3	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING		AS A CONSEC								
Ti C	3	CAUSE (Disease or injury	C. DUE TO (OF	AS A CONSEC	NIENCE OD				-			
TO TO		thet initieted events resulting in deeth) LAST	JOE 10 (OF	AS A CONSEC	DENCE OF):							
<u> </u>			d									
ws any inju	Y.	PART II. Other aignificant condition	e contributing to de	ath but not re	esulting in	tha underl	ying ceuse (given in F	Part i. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
E E	3								1 YES 2	/		COMPLETION OF CAUSE OF DEATH?
NOWS	= 11											1 YES 2 NO
		DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEA	TH YES	M NO	☐ UNC	ERTAIN				
Z W Z		25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only						
Or Hem	5	YES 2 NO	HOSPITAL:	VOutpetlant 3		OTHER:	Home 5 Re	aldenca /	Other (Specify)			
		27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJ (Month, Day,		28b. TIME INJUI	OF 28c.	INJURY AT WORK?		28d. DESCRIBE HOW IN	JURY OCC	URED	
RV DH	- 10	Accident Investigation	26s. PLACE OF IN	JURY — At hor	ne farm str		YES 2	100	281 1 OCATION (Commit			
COMPLETED		8 Could not be determined	building, atc.	(Specify)	,,	out, factory, t	AITCE	İ	281. LOCATION (Street as City or Town, State)	na Number	or Hurai H	oute Number,
E 10		29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, der	oth occurred	at the Ilma,	date and place	and due t	o the cause(s) and man	ner as state	ad.	
			R: On the beats of axam									and manner as stated.
MPORTANT: If item	, II	296. SIGNATURE AND THE OF CERTIFIE	B 60				29c. LICE	ENSE NUMI	BER	29d. DATE	SIGNED	(Month, Day, Year)
<u>₹</u> E		30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALLET	DE DEATH #7	1 020 /*		I	1/2	166	1	125	195
		HN- We	1.	O Nov	Then	Au	HAZ	P12	Tour 6	20		
		31. DATE FILED (Month, Day, Year) APR 2 5 199	32. PEGISTRAR'S	SIGNATURE	. 2 41		119	100	101011 10	- 4		
L		MIL 6 9 133	3	A RESULT AND	Wall,							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

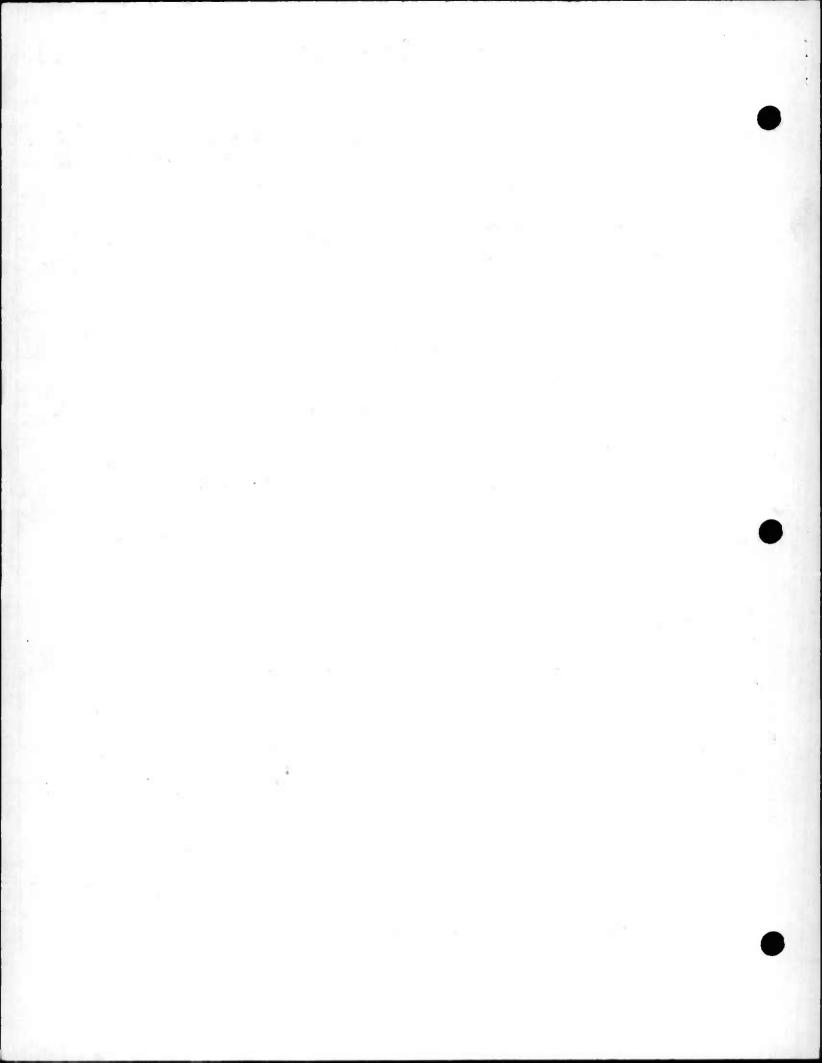
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. M BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERT	IFIC	ATE OF	DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		-503	3. TIME OF DEATH
	MARGERITA MARG	ARITA		T	ARBER	T		AY O	YEAR	
			AGE (In yrs. lest birtho	fay) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.0	9.5	7:55A M PLACE (State or Foreign
	218-18-9992	I □ M 2 😿 F	79 YR	400	THE DAYS	HOURS MIN.	(Month, Day, Year)	1000	Countr	γ)
	9a. FACILITY NAME (If not institution, give stree	et and number)		- 40	CITY TOWAY	F EDIT LOCATION OF DE	bruary 7			
Œ			D						NTY OF D	
[일	HARFORD MEMOR	TAL HOS	r.		DAVKE	DE GRA	ACE	ППА	RFOR	.U
DIRECTOR	10a. STATE 10b. COUNTY		10c.	CITY, TO	WN OR LOCAT	TION				10d. INSIDE CITY
E	Maryland H	arford			re de					LIMITS?
	10e. STREET AND NUMBER			114		. ZIP CODE		140 - 6-	1701	1 XXYES 2 NO
FUNERAL	41/5 Wahatan Tand	dem De-1			101					VHAT COUNTRY?
Z	4145 Webster Lapi					21078				States
	1 Never Married 2 Married	2. WAS DECEDENT EV FORCES? 1	YES 2 NO		13. WAS DEC	ENDENT OF HISPAN ecity Cuban, Maxica	IIC ORIGIN? (Specify Yen, Puarto Rican, etc.)	s or No-	14. RACE Black	American Indian, t, White, etc.
B	3 🖾 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES			2 NO Specify				White ■ White
COMPLETED	(Specify only highest grade co.	mpleted)	(Give kind	of work	AL OCCUPATION done during moined.)	of working	16b. KIND OF BU	SINESS/IN	DUSTRY	
اڄ	_	College (1-4 or 5+)	41 11 50							
3	12 17. FATHER'S NAME (First, Middle, Last)		Homem	akei			Her O		ome	
						16. MOTHER'S NA	ME (First, Middle, Maider	Surname)		
H	Lloyd Ralph Kelly						ia Mathias			
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADD	RESS (Street a	nd Number or Rural I	Route Number, City or Tov	vn, State, Zip	Code)	MD
-	Mike Tarbert		608	Sout	h Wash	nington S	Street, Ha	vre d	le Gr	ace 21078
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation 3 ☒ Remove	I from State	20b. PLACE AND DA	TE OF DE	SPOSITION (Na	me of	OATE 20c. LC			
	4 Donation 5 Other (Specify)		Crematio	or other p	ecial:	ists	4/10 Med	ia. F	enne	vlvania
	21. SIGNATURE OF BUNERAL GENVICE LICEN	SEN /	7		22 NAME AN	ID ADDRESS OF EA	CHITY			
	1/6ht 11	in			Crouc	h Funera East, M	1 Home, 12	.7 So	uth N	Main Street
	23. PART I. Enter the diseases, or complications that beused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate									
	Interval Between									
	disease or condition Do. C. L.									
H	resulting in desth)	rertoro	iton o	7	esoph	agus v	with comp	licat	tion	
		OUE TO (OR	AS A CONSEQUENC	E OF):	U	V	U			
8	Sequentially list conditions, b.	Bill was to -	40 4 00000			•				
F	If any, leading to immediate cause. Enter UNDERLYING	DOE TO (OR	AS A CONSEQUENCE	E OF):						
CERTIFICATION	CAUSE (Disease or Injury C	DUE TO CO.	48 4 CONCESSION							
E	that initiated events resulting in desth) LAST	DUE TO (OR	AS A CONSEQUENCE	E OF):						
E II	d									
	PART II. Other aignificent conditions of	contributing to dea	th but not resulting	na In th	e underlylar	Ceuse olven in	Part I. 24s, WAS AN	AITTOREY	041	MEDE ALTONOM COMMUNE
EDICAL	Diabetes mellitu	Harrele	ΔΨ	1. 1	Cal	0 7	PERFOI		246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ā	11 1 D	singertens	ICE PITHEROSE	Lent	c card	orvencular L	DEA THES	□ NO		COMPLETION OF CAUSE DF DEATH?
Σ	70,000	LINCOAL.	DANA				_			1 YES 2 NO
ž I	DID TOBACCO USE CONTRIB	BUTE TO CAUSI	OF DEATH	YES [UNCERTAIN	1 🗆			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF D	_						
S	The state of the s	☐ Inpetient 2 XER/	Outpatient 3 🗆 DO		HER: Nursing Home	5 🗆 Rasidenca	6 Other (Specify)			
돈	27. MANNER OF OEATH	28a. DATE OF INJU (Month, Day, Ye	RY 28b.	TIME OF	28c. INJ	URY AT	28d. OEŞCRIBE HOW	NJURY OC	CURED	
	1 Natural 5 Pending	-		INJURY	M 1 V		therapeuti	c proc	edu	re
BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJ	URY — At home, fan	m, street				_	or Rural D	oute Number
COMPLETED	4 Homicide datermined	building, etc. (Specify)	soft			City or Town, State	Harford	Hema	oute Number, but
<u>u</u>	29a. CERTIFIER		7.	-			Hay tend	Cr. hD		-
4	(Check only									
Ö	(MEDICAL EXAMINER:	On the basis of axamir	ation and/or investig	ation, in	my opinion, de	eath occured at the	time, data and placa, ar	nd due to th	na cause(s)	and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUM	BER	29d, DAT	E SIGNEO	(Month, Day, Year)
8	News 1	. Chut	2.0		- 1	O.C.1	M.E		PRII	
2	30. NAME AND ADDRESS OF PERSON WIFO C	OMPLETED CAUSE OF	OEATH (ITEM 27) (1	vpe, Print	,				1 1/11	1 00/00
			111 PE	NN	STREE	ET, BAL	TIMORE,	MARY	LANI	21201
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	BIGNATURE	-						
	APR 1 2 1995	Juli: As.	dear Randal	19						
	111 11 2 10 00	Juna Will	MOON WITHOUT	-0						- 1



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

MULTIPLE ORGAN FALLURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY or DUE TO (OR AS A CONSEQUENCE OF): D			REGISTRAR				CERTIF	ICALE	OF DE	AIH		REG. NO		_	
THOMPSON ADDITIONS A			1. DECEDENT'S NAME (First	I, Middle, Last)							2. DAT	E OF DEATH		VEAR	3. TIME OF DEATH
A SOUR SECRET POWER OF THE PARTY AND A CONTROLLED TO BE A SOURCE O		1 2	CLARA	19	MILDRED		TH	OMPS	ON		mon.				2:30 am H
TO STATE AND THE PROPERTY AND THE PROPERTY OF		- 0			5. SEX	6. AGE (In yrs			T	DER 24 HRS.	7. DAT		100		
Senter Labour Deposition of Policy In the Control of Section 1 of Sect		1 8	041-22-9042		1 M 2 F	85	YRS.	MONTHS	DAYS HOU	S MIN.				Country	1)
Bailth Joseph Medical Center Townson, Manyland Bailth Joseph Medical Center Townson, Manyland Bailth Joseph Medical Center The STREET MONOGRAM The STREET WAS NOT BEEN TOWNSON AND A STREET WAS NOT BEEN TOWNSON, MARY TOWNS	8		On EACH ITY NAME // not is	matitudina al-	atmost and are built			101 000				e 4, 19	V		
TO COUNTY AND MARKET A	es es	0						9b. CITY,					9c. COU	NTY OF DI	EATH
TO COUNTY AND MARKET A		Ö			edical Cente	er			Towso	n, Ma	rylan	d		Baltin	поге
TO COUNTY AND MARKET A	-	5													
TO COUNTY AND MARKET A	ages	1 2 1	10e. STATE	10b. COUNT	Υ		10c, CIT	Y, TOWN OF	LOCATION						10d. INSIDE CITY
Section Sect	£.	0	Maryland		Harfor	d				oppat	towne	9		_	
SOURCE ADDRESS Security Source	E	4	10e. STREET AND NUMBER				-						10g. CITI	ZEN OF W	
So to the control of	ts.	E	604 A	Harbor	eida Dri	770				2.	1005				
So to the control of	tran tran	Z		IICII DOI			ADMED	40.11					L		
So to the control of	ZO Jasic Maria	딥		Married	FORCES? 1	YES 2	⊠ NO	13. W	yes, specify C	uben, Mexic	an, Puert	IN? (Specify Yes o Rican, atc.)	or No —	14. RACE Black	- American Indian, White, stc.
So to the control of	0 2 2	≿			IF YES, GIVE Y	MAR OR DATES	3	1	☐ YES 2 🔀	VO Spec	ity:			Specifi	y:
The state of the s	S the														white
The state of the s	Se aff		15. DEC (Specify onl)	DEDENT'S EDU by highest grade	ICATION completed)	161	Give kind of	USUAL OCC	CUPATION	nekine	10	Bb. KIND OF BUS	BINESS/IND	USTRY	
The state of the s	12 S	ių	Elementary/Secondary (6	0-12)	College (1-4 or 5	+)	life. Do NOT u	se retired.)							
The state of the s	D sp p	<u>a</u>	8				Homema	ker				Home			
The state of the s	e ho	0	17. FATHER'S NAME (First, M	fiddle, Last)					16. M	OTHER'S N	AME (First	Mirktle Mairies	Sumamal		
23. PART I. Enter the diseases, or confidence of the control of th	7 5 8 5) 170	mleki									/ /1-\
23. PART I. Enter the diseases, or confidence of the control of th	E eee R	1 W I			, 10	POTDICT									(u/k)
23. PART I. Enter the diseases, or confidence of the control of th	sho sho	0													
DO DE TO (OR AS A CONSECUENCE OF): Sequentially list conditions, resulting in death) NO TO DE TO (OR AS A CONSECUENCE OF): Sequentially list conditions, resulting in death) NO TO DE TO (OR AS A CONSECUENCE OF): DUE TO (OR AS A CONSECUENCE	. 2 8 .	1 ' 1	Edwin V. T	pompso	n		604	A Ha	rborsi	de Dr	cive,	, Joppa	towne	e, Mo	l. 21085
13.17 Cokesbury Road, Abingdon, Md. 21009 13.18 June 1998 and 199	T be a				414	20b. PL/	CE AND DATE	OF DISPOSIT	TION (Name of		DA	TE 20c. LO	CATION -	City or Ton	vn, State
13.17 Cokesbury Road, Abingdon, Md. 21009 13.18 June 1998 and 199	O Go Go	1 4			lowal from Stats	MEtery	SE B	enedical.	cts Ce	meter	~ 4	/15/95	Bloom	nfiel	d (Tr
13.17 Cokesbury Road, Abingdon, Md. 21009 13.18 June 1998 and 199	Page 1		21. SIGNATURE OF FUNERA	L SERVICE/LI	DENSEE / /		7.2	22. N	AME AND ADD	RESS OF E	ACILITY	13 33 .	DIOM	LIC1	.u, C1
13.17 Cokesbury Road, Abingdon, Md. 21009 13.18 June 1998 and 199	T sera		X191100	11/1/1	1//0	W.M.	1/	HO	ward K	. McC	Comas	III F	unera	al Ho	me, P.A.
Approximate the adjustment of the state of t	A Sala		11/000//	MX	· 100	MUM.	74	_ 13:	17 Cok	esbur	V Ro	oad. Ab	inado	n. M	M. 27009
MULTIPLE ORGAN FALLURE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A	0 m 2 m		23. PART I. Enter the d	isesses, pr	complications tha	at caused tha	death. Do	not antar ti	ha mode of	dving au	ch ss cs	rdiec or reapi	retory ser	net	
MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, it any, leading to immediate cause, error underlying death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE (Ohease or Injury that inhisted events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN TO FEMALE FOR CAUSE OF DEATH (The AS A CONSEQUENCE OF): 24. WAS AN AUTOPSY PROMODY ANALASE FOR CAUSE OF DEATH YES NO UNCERTAIN TO FEMALE FOR CAUSE OF DEATH (Check only one) 1. YES 2 WANNERS OF DEATH TO FEMALE AND TO THER: 1. YES 2 WANNERS OF DEATH TO FEMALE AND TO WAS A CONSEQUENCE OF): 25. WANNERS OF DEATH TO FEMALE AND TO WAS A CONSEQUENCE OF): 26. PLACE OF DEATH (Check only one) 27. WANNERS OF DEATH TO FEMALE AND TO WAS A CONSEQUENCE OF): 28. WAS AN AUTOPSY PROMODY ANALASE FOR CAUSE OF DEATH YES NO UNCERTAIN TO FEMALE FOR CAUSE OF DEATH TO FEMAL	/ \ > =		shock, Dr h	eart tallure.	Liat only Dna Cat	use on asch	line.		201-1-1-1	,				001,	Intervel Between
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYNG CAUSE (Dieseas or Injun Indexh) LAST DUE TO (OR AS A CONSEQUENCE OF): d. DU				nel											Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYNG CAUSE (Dieseas or Injun Indexh) LAST DUE TO (OR AS A CONSEQUENCE OF): d. DU	matint, t			→	. MULT	IPLE OR	GAN FA	WURE							
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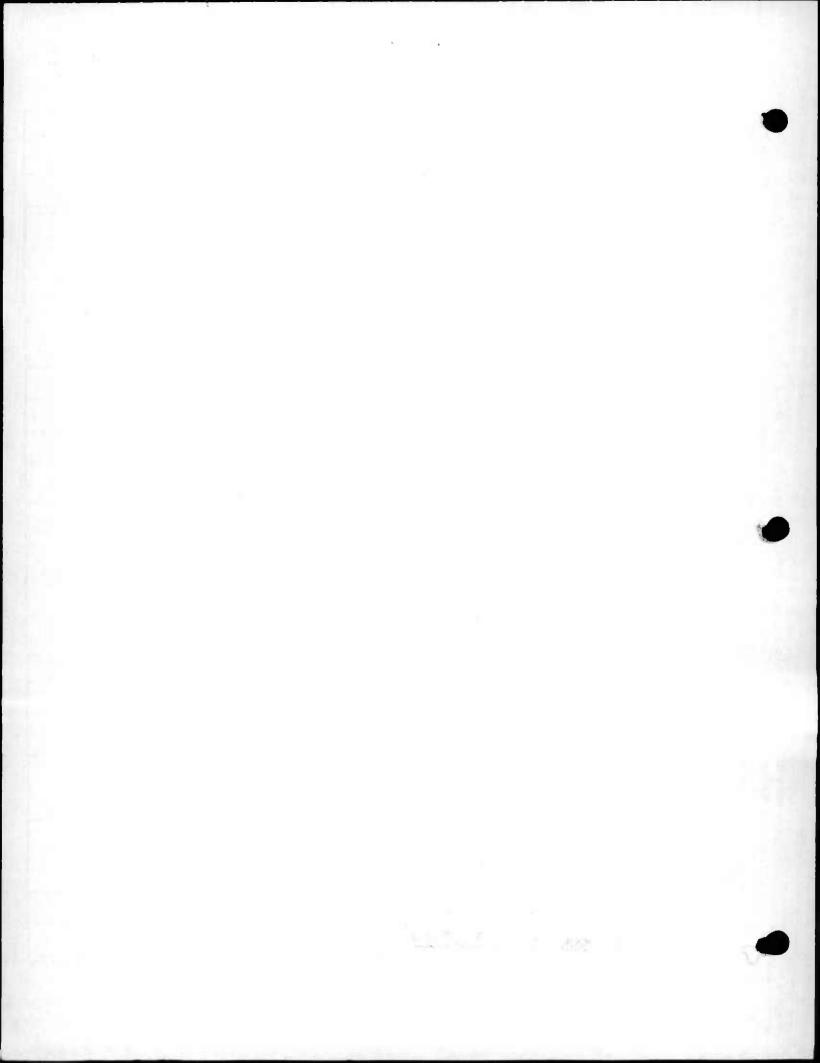
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spital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

after death. Page 6 may be retained by the hospital or attending physician,	y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should noval.	cal examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
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11	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Yeer)	I Count	NPLACE (State or Foreign
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CIC	RESIDENCE OF DECEDENT		ILAI	Ue	Kland		Gar	rett
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	10e. STREET AND NUMBER	Freston		Kingwoo				YES 2 NO
RA	105 Julie St.			10	26537		10g. CITIZEN OF V	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DE		IIC ORIGIN? (Specify Ye	US.	A E — American Indian,
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 XNO	If yee, s	ecify Cuben, Mexical	n, Puerto Ricen, etc.)	Blec Spec	k, White, etc.
		<u> </u>						"" White
	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of w	USUAL OCCUPATI ork done during m retired.)	ON ost of working	16b, KIND OF BU	SINESS/INDUSTRY	
PL	Elementary/Secondary (0-12)	College (1-4 or 5 +)	salesma			Inaura	nce Agen	CV
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NAI	ME (First, Middle, Meiden		-1
BE (Charles D. V	Vebster			a Rinehart		
2	19e. INFORMANT'S NAME (Type/Print)	-				Noute Number, City or Tow		
	W. Douglas Webst				ille St.		ta, WV 2	
	16 PBurlel 2 Cremetton 3 Rem	coval from State Cen	n.PLACE AND DATE On the left, cremetory or off LYONA COM	her place)	4-21-19	1	CATION — City or To	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	itora cen			ght Funera	urora, W	·va.
	· arthur	4. Wright	_					
	23. PART I. Enter the diseases, or	complications that caused	the deeth. Do n	ot enter the mo	de of dving, auch	Ave. Terra	Alta, W	V ZO 704
	ahock, or haert fellure. IMMEDIATE CAUSE (Final	List only one ceuse on e	ech iine.		0		andly andda,	Interval Between Onast and Death
1	disease or condition reaulting in death)	· Tuls	2000	- 5	lana			
	0	DUE TO (OR AS A	CONSEQUENCE OF	7	1	+ Fai	0	
ON O	Sequentially ilet conditiona,	DUE TO JOB AND	CONSEQUENCE OF	TO f	acus	/ac	ten.	
YA.	if any, leading to immediate cause. Enter UNDERLYING		sometaobite of					i i
Ĕ	CAUSE (Diseese or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	i i				
CERTIFICATION	resulting in deeth) LAST	d						
CALC	PART II. Other significent condition	a contributing to deeth b	ut not resulting in	the underlyin	g cause given in I	Part I. 24e. WAS AN	AUTOPSY 24b.	WERE AUTOPSY FINDINGS
Š						PERFOR	IMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME							XXIII	OF DEATH? 1 YES 2 NO
PHYSICIAN: MEDIC							-	
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Che	ck only one)		
₹	1 VES 2 NO	1 X Inpatient 2 ER/Outp	atlent 3 DOA 28b. TIME		e 5 🗆 Reeldence 1			
ВУ Р	1 Netural 5 Pending	(Month, Day, Year)	INJU		RK?	28d. DEŞCRIBE NOW II	NJURY OCCURED	
	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, st			281. LOCATION (Street e	and Number or Rural R	loute Number,
	4 Nomicide determined	bulleting, etc. (Spec	414)			City or Town, State)		
COMPLET	290. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurred	st the sime, date	end place, end due t	to the cause(e) end men	ner ee stated.	
Š	one) 2 MEDICAL EXAMINE	, in my opinion, d	eath occured at the t	lime, date end place, en	d due to the ceuse(e) end menner ee stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIES		29c. LICENSE NUM	BER	29d. DATE SIGNED			
ဋ ြ	30. NAME AND ADDRESS OF PERSON WIN	O COMPLETED CALLED		D26568 ► 4-19-95				
	Roger A. Lewis, M				ra Alta	WV 26764		
H	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE -	v 1.E.	-u Alla,	W 20704		
	APR 2 0 1995	Jahr Studior	Roball .					
		U						DUNIU 48 Day 4700



		1 - FOR STATE REGISTRAR		STATE OF MAR					EALTH AND I	MENT	AL HYGIE			
	1	1. DECEDENT'S NAME (First,	Middle, Lest)	Wiedr	ick					MO		DAY	YEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUME	BER		GE (In yrs. les		IF UNDER 1 YE	\rightarrow	IF UNDER 24 HRS. HOURS MIN.	7. DAT	TE OF BIRTH onth, Day, Year)	22	8. BIRTHPL Country)	ACE (State or Foreign
3 should		212-22-550 9a. FACILITY NAME (If not in	/		67	1110.	9b. CITY, TO	MN O	R LOCATION OF DE	<u>lOct</u>	4,	1927 9c. cou	Penn	sylvania ""
2,	СТОВ	Fallston G	eneral	Hospital			Falls	to	on			Ha	rford	
permit. Pages 1,	DIREC	10a. STATE	10b. COUNTY			10c. CITY	TOWN OR L	OCATI	ION				10	Dd. INSIDE CITY LIMITS?
ermit.	1	Maryland 100. STREET AND NUMBER		Harford		L	Abero		ZIP CODE		_	10g. CIT		YES 2 NO
Sit	FUNERAL	_348 Union :	Street						21001			Ţ	J.S.A.	
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. medical examiner must be notified at once.	BY FUR	11. MARITAL STATUS 1 Never Married 2 52 3 Widowed 4 Divo		12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O	ES 2 P	MED NO	If yes	s, spe	ENDENT OF HISPAI scify Cuban, Mexica 2 M NO Specif	n, Puer		Yes or No—		- American Indian, White, atc.
attend use as	TED		EDENT'S EDUCA y higheat grade o		(G	ive kind of w	JSUAL OCCUI				16b. KIND OF	BUSINESS/INI		ce
pital or atte	COMPLET	Elementary/Secondary (0	0-12)	College (1-4 or 5+)		sina	retired.)				Medica	a 3		
the hospita detached 1 once.	OM	17. FATHER'S NAME (First, M	liddle, Last)		TIVUL	sing			18. MOTHER'S NA					
should be	BE	Raleigh And			40		1000E00 (0)				Wells			
e retained e 5 should r notified	임	Mr. Walter		drick, Jr.					nd Number or Rurel treet, Z					21001
age 6 may be director, page er must be		20a. METHOD OF DISPOSIT 1 Burlal 2 Crematic 4 Donation 5 Other	on 3 🗆 Remon		cemetery, cre	AND DATEO	FDISPOSITIO	N (Nar		D		LOCATION —	City or Town	, State
death. Page tuneral dire I. examiner		21. SIGNATURE OF FUNERA	R SERVICE LICE	NSEE) . M	inni		22. NAN	E AN	ng-Cargo	CILITY				IA
Inc.		23. PART I. Enter the shock, pr I IMMEDIATE CAUSE (Fir disease pr condition resulting in death)	eert fallure. L	omplications that caused the property of the p	used the de on each line	eath. Do no.	ot enter the	mod		h es c	erdiec or re	epiratory ar	rest,	Approximate Interval Between Onset and Death
th certificate be executed ending physician and con I Hygiene prior to burial, or other traumatic en	CERTIFICATION	Sequentielly list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initieted events resulting in death) LAS	diata iNG iry c.	DUE TO (OR										
4 a g a	DICAL	PART II. Other eignifica	ent conditione	contributing to dee	th but not i	reculting is	n the under	lying	g ceuse given in	Part I.	PERI	AN AUTOPSY ORMED? 2 NO	A C	TERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
he law requires that has been signed e Dept. of Health am 23 shows any	A: ME	DID TOBACCO U	ISE CONTR	IBUTE TO CAUSI	E OF DEA	TH YE	S 🗆 NO	B	UNCERTAI				1	YES 2 NO
SICIAN: The law certificate has b the State Dept.	PHYSICIAN	25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO		HOSPITAL:			OTHER:		e 5 🗆 Rasidenca	• 🗆 0	the (Specific)			
NG PHYSICIA fer this certil eath with the marked, or			Pending	28a. DATE OF INJU (Month, Day, Ye	JRY	28b. TIME INJU	OF 260	. INJI	URY AT RK?	_	DESCRIBE HO	W INJURY OC	CURED	
= 47 55	TED BY	3 Suicide 8	Could not be determined	28s. PLACE OF IN- building, atc.	JURY — At he (Specify)	ome, farm, s					OCATION (Streetly or Town, St		r or Runil Rou	ite Number,
로 되었는	COMPLET													
THE HOSPITAL THE FUNERAL I filed within 72 h	BE CO		OF CENTIFIEN	and	no	_	y vpote		29c. LICENSE NU		preve			100th, Day, Year 1995
₽₽≥₹	5	30. NAME AND ADDRESS O	F PERSON WHO	COMPLETED CAUSE OF	F DEATH (ITE	M 27) (7000	Print)	7	1.15	1	- A-	7/11	A C	2

LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

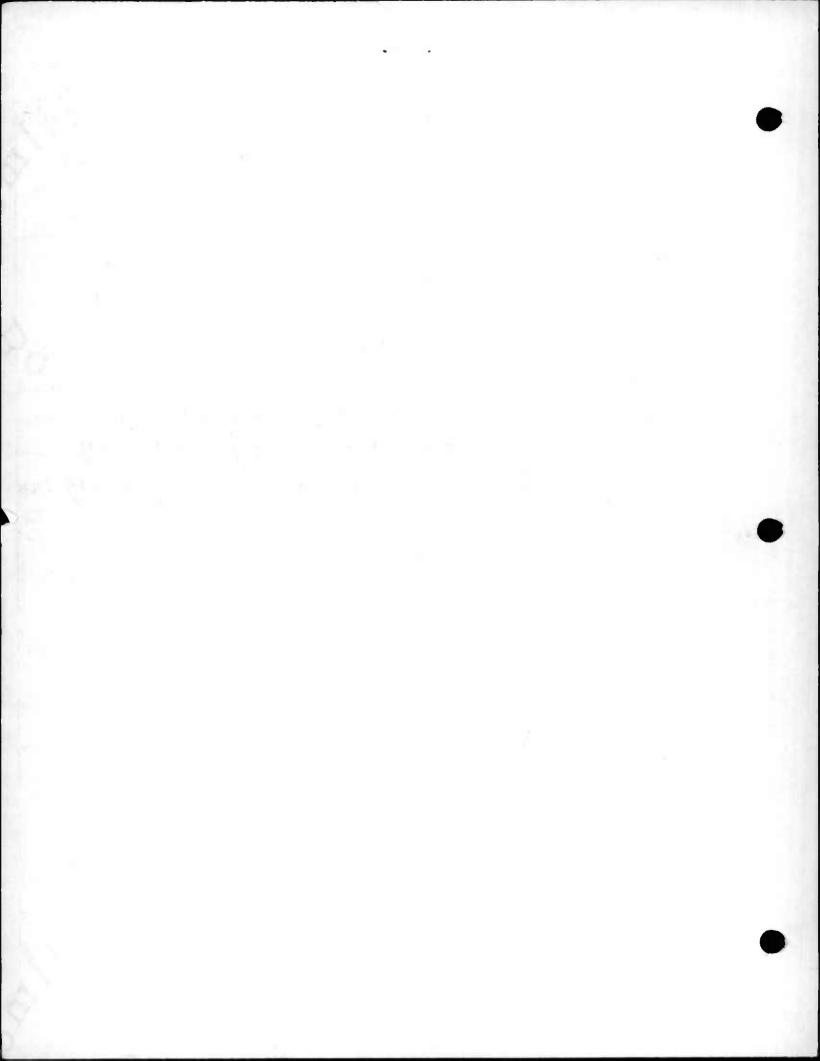
31. DATE FILED (Month, Day, Year)
APR 2 4 1995

anding physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

rs after death. Page 6 may be retained by the hospital or atte	n by the funeral director, page 5 should be detached for use a removal.	dical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)	s WA	SHING	70n)	2. DATE OF OEATH MONTH DAY	7-1995	3. TIME OF DEATH A
		S. SEX S. AGE (In yrs.	YRS. MONTH		7. DATE OF BIRTH (Month, Day, Year) MAY 7. 192	9. BIRTH Count M.A	Ryland
DIRECTOR	SOUTHERN MAN	yland Hospi	1774L	Chinton	EATH /	PRINCE	
	MARYAND Princ	e George	Λ	N OR LOCATION			10d. INSIDE CITY LIMPS? 1 YES 2 NO
FUNERAL	Rt / Box 204	2. WAS DECEDENT EVER IN U.S.	ARMED 1	2060 8		USA	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2	NO	If yes, specify Cuban, Maxic. 1 ☐ YES 2 🔀 NO Speci	an, Puarto Rican, etc.)	Black Spec	k, White, atc.
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	FION npleted) 16a. College (1-4 or 5+)	OECEDENT'S USUAL (Give kind of work doi life. Do NOT use retired	ne during most of working i.)	16b. KIND OF BUSIN	ESS/INOUSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last)	Washinston	Siries	Elan	ME (First, Middle, Malden Sur	mame)	
5			3002 G	ss (Street and Number or Rural	Route Number, City or Town, S		20602
	20e. MSTROD OF DISPOSITION 1 Surial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. SIGNATURE OF MUNERAL SERVICE LICEN	of from State	CEANDDATE OF OISP crematory or other place	ce)	1/20/25 Cli	ntun	mn, State
	Horn !	20		Alams Funer	1 Hone L	quasco	MT) 20608
	23. PART I. Enter the diseasea, or conshoot or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	Ren a Due to (OR AS A CON)	Faul	er the mode of dying, aud	h as cerdiac or respirat	day errest,	Approximete interval Batween Onaet end Death
ATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DOE TO (OR AS A CONS	muses	athy			Jus
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	SEOUENCE OF):				
MEDICAL	PART II. Other significent conditions of	ontributing to deeth but no	t resulting in the	underlying ceuse given in	Pert i. 24a. WAS AN AU PERFORME	D?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: M	DID TOBACCO USE CONTRIE		ATH YES		N D		1 TYES 2 NO
S	EXAMINER?	OSPITAL:	ОТН		6 Other (Specify)		
ВУ РНУ	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJU	IRY OCCUREO	
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — At building, atc. (Specify)	home, farm, streef, fa	actory, office	281. LOCATION (Street and City or Town, State)	Number or Rural F	Poute Number,
COMPLETE		N: To the best of my knowledge, On the basis of axamination end/) and manner as atated.
IO BE	296. SIGNATURE AND TITLE OF CERTIFIER	How ms	0	29c. LICENSE NUI	923 1	AD Y	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO C	Seal M.D.	13600	Browdywin	e Rd Gra	medy we	ar MD
	31. DATE FILE APR 2 4 1995	32. REGISTRANTS SIGNATURE	Kardall			,	5



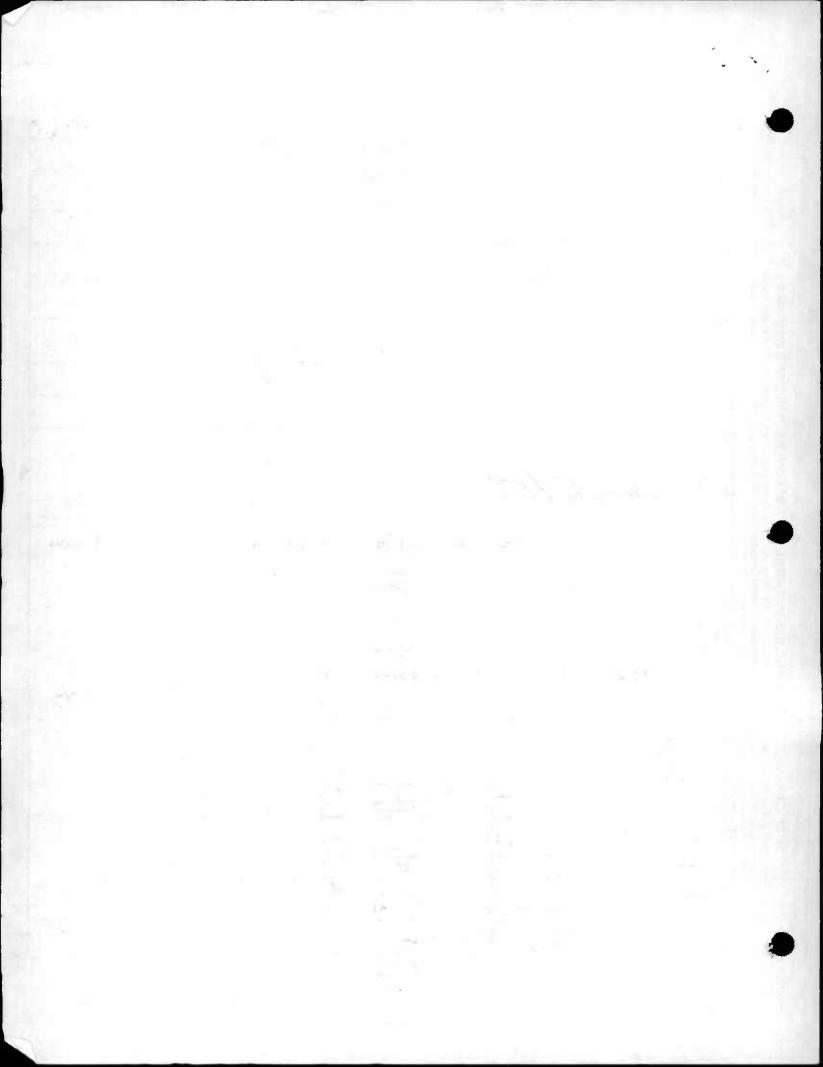
at the common of the heapten of antennan prigorent.	page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		be notified at once.
ENDING FIRE ION THE ION THE ION THE DESTITION OF COUNTY AND THE ION THE ION THE ION THE TRANSPORT OF THE ION T	CTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	al examiner must be notifi

•	FOR	STATE OF MARYLAND /	DEDAD.	TMENT OF	UEAITU AND	MENTAL UVCIEN	ıe	• (1 1309	
	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	CE		CATE OF		REG. NO		YEAR	3. TIME OF DEATH	
	Margaret Estel					April 23	, 19	95	3:30A.m	
		SEX 6. AGE (In yrs. las 78	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 2 1	916	6. BIRTHI Country Mar	PLACE (State or Foreign yland	
TOR	99. FACILITY NAME (If not institution, give street 1316 Ridge Rd. RESIDENCE OF DECEDENT	and number)	1-1		or LOCATION OF D		9c. COUN	rol		
DIRECTOR	10a. STATE 10b. COUNTY	rroll		tminst					10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 1316 Ridge Rd.			1	01. ZIP CODE 21157			S.A	HAT COUNTRY?	
BY FUN	11. MARITAL STATUS 12 1	WAS DECEDENT EVER IN U.S. AR FORCES? 1 TYPES 2 THE IF YES, GIVE WAR OR DATES		If yes, s		NIC ORIGIN? (Specify Year, Puerto Rican, atc.) fy:	e or No—		- American Indien, White, etc. 7: White	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com Elementary/Secondary (0-12) O	pleted) (G ollege (1-4 or 5+)	ve kind of w Do NOT us	USUAL OCCUPAT vork done during n e retired.)		Homem		USTRY		
BE COM										
10	196. INFORMANT'S NAME (Type/Print) Anna M. Lilley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Ridge Rd. Westminster, Md. 21157									
	20b. METHOD OF DISPOSITION 1 St Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) Middletown Cemetery 4/25 Middletown, Md.									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home 21157 254 E. Main St. Westminster, Md. 23. PART I. Enter the passesses, pr compilections that coused the deeth. Do not enter the mode of dying, such ea cardiec or respiratory arrest, Approximate									
CERTIFICATION	ahock, of heart fellure. List	DUE TO (OR AS A CONSECUENT OF TO (OR AS A CO	Cho QUENCE OF	olangio			iratory arr	est,	Approximate interval Between Onset and Deat	
PHYSICIAN: MEDICAL CI	PART is Other significant conditions contributing to death but not resulting in the underlying cause given in Bert 1 245 was an autopacy 245 we								WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ICIAN		OSPITAL:		OTHER:	PLACE OF DEATH (C					
BY PHYS							CURED			
	# Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, :	street, factory, of	fice	28f. LOCATION (Street City or Town, State	and Number	or Rural F	Route Number,	
COMPLETED	one)	N: To the best of my knowledge, do On the best of examination end/or							i) and manner ee stated.	
TO BE CC	296 SIGNATURE AND TITLE OF CERTIFIER	Calvu ms	W		29c. LICENSE NO		_	E SIGNED	(Month, Day, Year)	

HO MAS GALUM MO 542 WASHINGTON

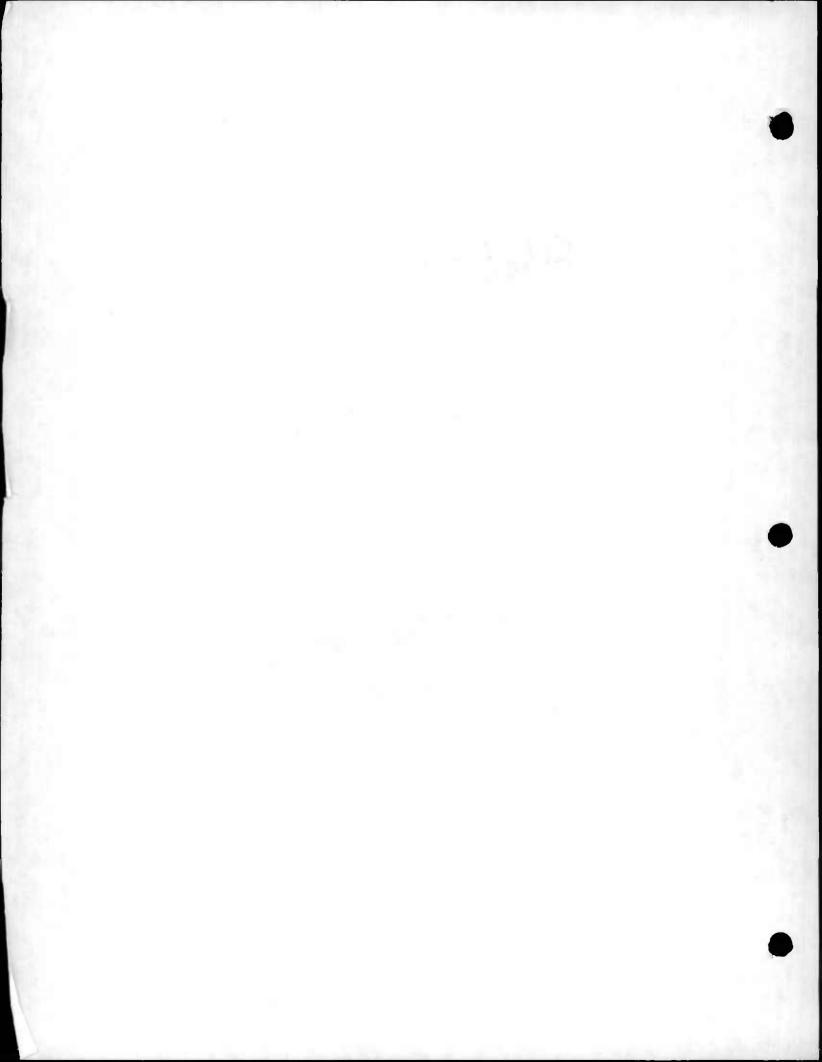
32. REGISTRAT'S SIGNATURE

1 HOMAS 31. DATE FILED (Month, Day, Year), APR 24



Ellel 7. White VOID
CERTIFICATE # 25-13896
SEE
CERTIFICATE #

95-15677



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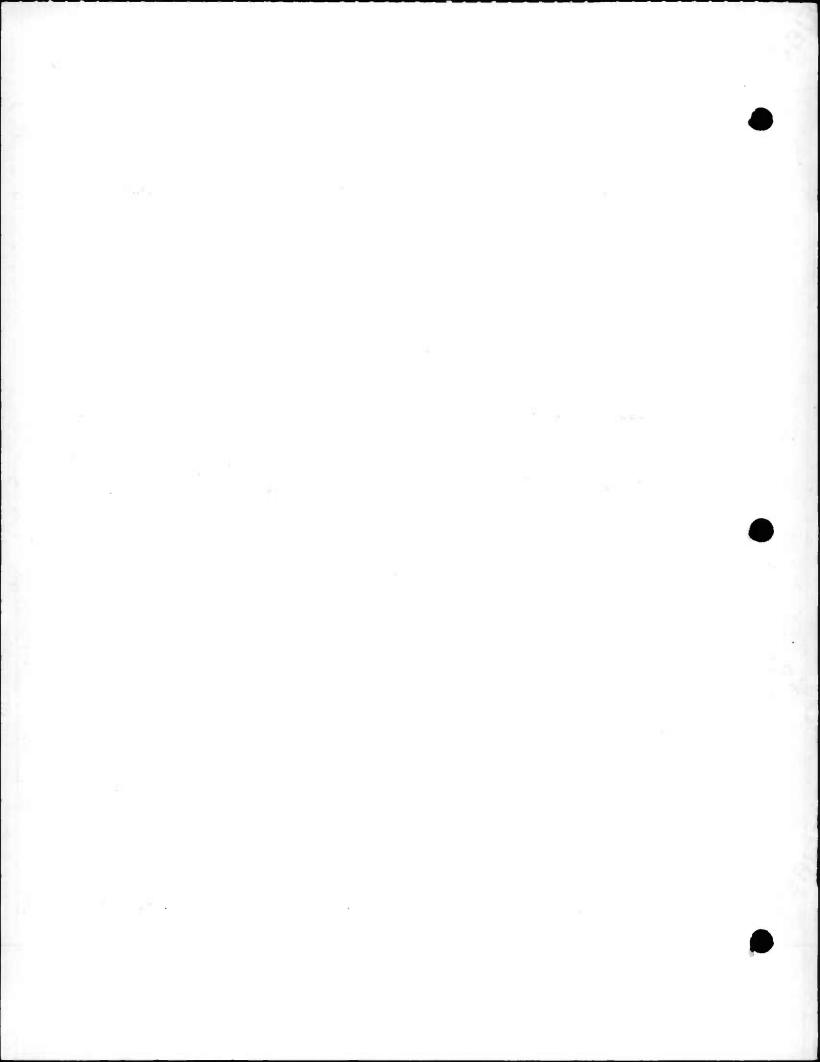
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death. Page 6 may be retained by the ho	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral aftertor, page 5 at	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	10	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH april YEAR 9:40 Doro H. would les ood 25 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 X F 88 VRS 086 18 8507 22,1906 Auq. Massachusetts 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Silver Spring Holy Cross Hospital Montgomery RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 1 NO 10e, STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8505 Springvale Road 20910 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 YES 2 NO Specify B Snech 3 🔀 Widowed 4 🗌 Divorced White ETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Halsey BE not available 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Michael J. Zambito 8800 Eskridge Court, Gaithersburg, MD 20879 20a. METHOD OF DISPOSITION
1 反 Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State cometery, crematory or other place) April 17,1995 Riverview Cemetery Charlottesville, Donetton 5 Cher (Specify) Virginia 21 SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 M00689 Wisconsin Ave., Bethesda, Maryland 20814 Inter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the ky or heart feliure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Finel Onset and Deeth disease or condition (223 reculting in death) DUE TO (OR AS A CONSEQUENCE OF) obs CERTIFICATION Lrowie Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CHF COMPLETION OF CAUSE e wer ha 1 | YES 2 | NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☑ NO ☐ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) Inpellant 2 - ER/Oulpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCUREO 1 Natural BY 7eb 23 91 1 YES 2 NO 72/ 2 Accident Investigation 28e. PLACE OF INJURY — Al home, lerm, street, lectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rugal Routs Number-City or Town, State) 6 Could not be determined COMPLETED 4 Homicide Nursino Home 29a. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end manner ea stated. 2 DEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER **BE** 29d. DATE SIGNEO (Month, Day, Year) Euro 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8218 WIS SUSIN Acre APR 19 1995



REG. NO.

STATE REGISTRAR

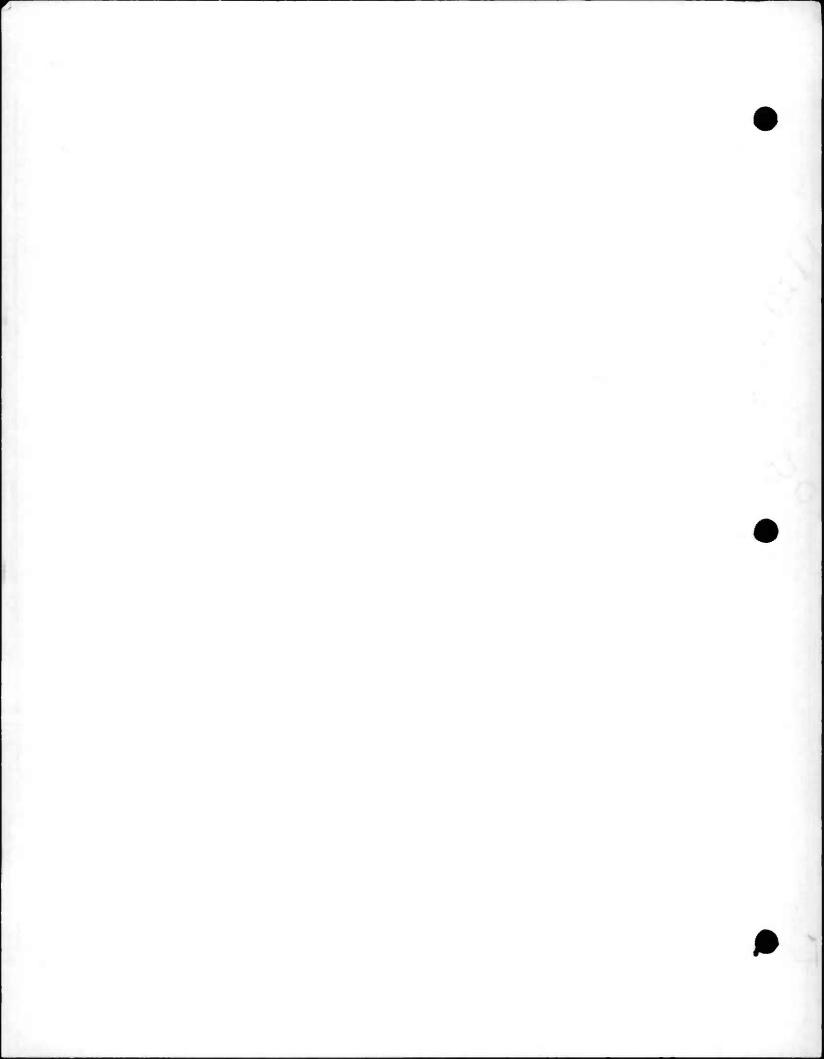
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VITAL B
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1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Matthew Weidman John 1995 April 12:25 14 PM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 578-09-8801 87 May 25, 1907 Washington D.C. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 X YES 2 | NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 237 Dale Drive for use as the burial-transit 20910 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify, Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 X Married Specify White BY 3 Widowed 4 Divorced 1942-1945 ED 16a. DECEDENT'S USUAL OCCUPATION
(Oive kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Ħ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 funeral director, page 5 should be detached Mailroom Foreman Newspaper 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 듁 Jacob Weidman Mamie Specht BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Josephine R. Weidman 237 Dale Drive Silver Spring, Maryland 20910 hours after death. Page 6 may be Pe 20e. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must 1 Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) HEaven Cemetery 4/17/95 Silver Spring, Maryland Gate of examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. 500 University BLvd. W. Sil. Spr. MD 20901 completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the daeth. Do not anter the mode of dying, such as cardiec or respiratory arrast, Approximata shock, or haart fallure. List only one cause on asch ilna. intarvai Between to burial, cremation, or IMMEDIATE CAUSE (Final Onset and Death the disease or condition . Pneumonia 5 Days resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): the death certificate be executed Quadriparesis CERTIFICATION and Sequantisliy list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate prior Enter UNDERLYING Anemia CAUSE (Disease or injury other 1 OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST -Mental injury, the PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS been signed by th AVAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH? PERFORMED? requires that 23 shows any 1 TYES 2 X NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate HOSPITAL:
1 X Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 X YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) و <u>ه</u> 27. MANNER OF GEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? with t 28b. TIME OF INJURY marked, 28d, DESCRIBE HOW INJURY OCCUPED 1 X Natural 5 Pending Investigation 1 YES 2 NO After the BY 2 Accident 26e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 69 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: A hours after ditem 28 is 6 Could not be 4 Homicide TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: It item 2 29a, CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. # MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE D07099 ▶ April 18, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Mayle, Jr., M.D. 10215 Fernwood Road #301 Bethesda, MD 20817 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE APR 19 1995 Stevel on Parket

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

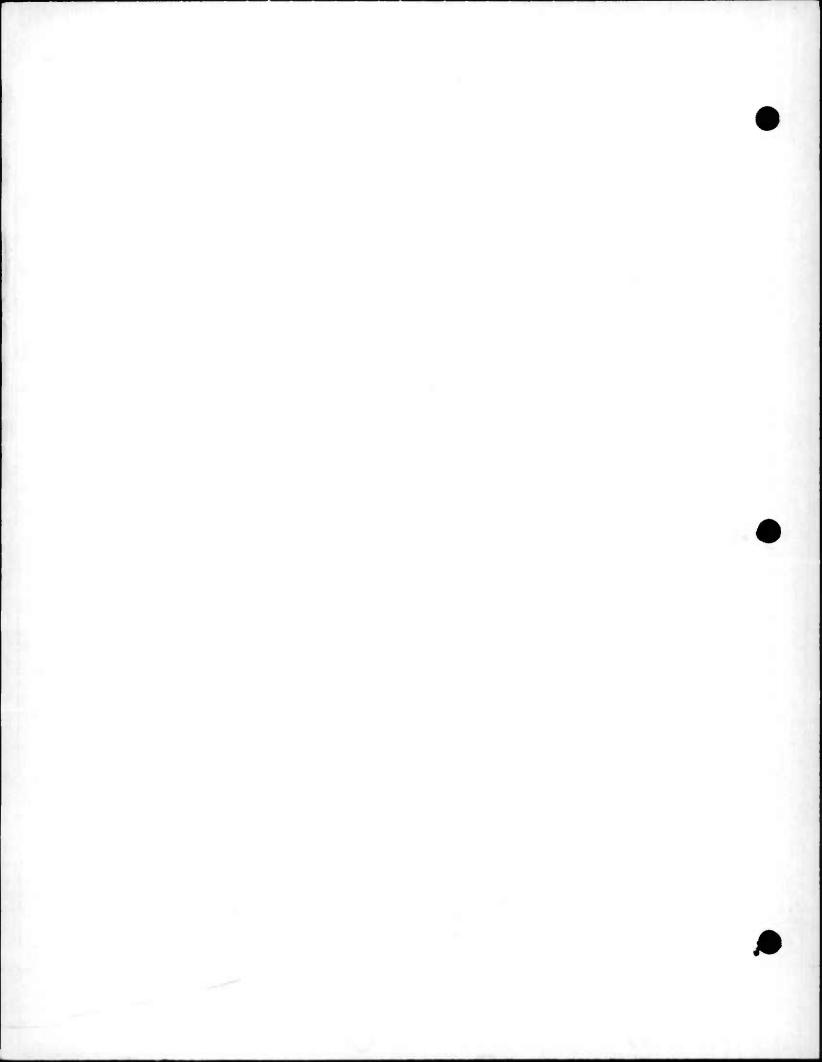
FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLE	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
il examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for val.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospital or	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or
BALTIMORE, MARYLAND 21	DIVISION OF VILAL RECORDS, P.O. BOX 68760

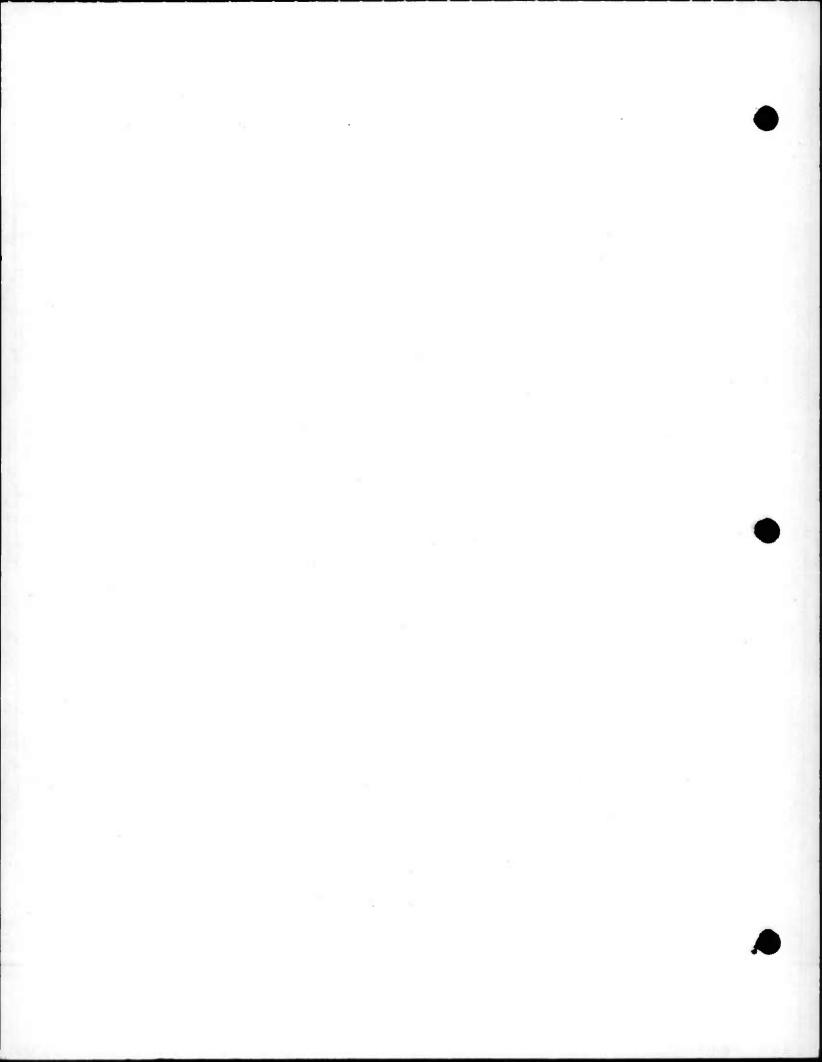
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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	288-07-0041		1 🔀 M 2 🗆 F	87	YR	MONTH	B DAYS	HOURS	MIN.	Nov.	2,1907	'	Mass	achusetts	
~	Sa. FACILITY NAME (If not in					9b. C	ITY, TOWN	OR LOCATI	ON OF D			9c. COUN	TY OF D	EATH	
70	Circle Mano	r Nurs	sing Home	2		ŀ	Censi	ngtor	n			Mo	ntgo	mery	
EC	10a. STATE	10b. COUNTY	Υ		10c.	CITY, TOW	N OR LOCAT	TION						10d. INSIDE CITY	
PIG	Maryland	Mor	ntgomery			Kensi	ingto	n					10d, INSIDE CITY LIMITS? 1 YES 2 X NO		
AL	10s. STREET AND NUMBER						101	. ZIP COD	E			10g. CITI	ZEN OF V	WHAT COUNTRY?	
FUNERAL DIRECTOR	4223 Evere	tt Sti	reet					2089	95				USA		
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U	S. ARMED	1	3. WAS DEC	ENDENT (OF HISPAI	NIC ORIGIN	(Specify Yes	or No-	14. RACE	— American Indian,	
BY	1 Never Married 2 3 3 Widowed 4 Divo		IF YES, GIVE V				1 TYES	2 A NO	Specif	en, Puerto R ly:	ican, etc.)		Speci	White	
	15. DEC	EDENT'S EDU	CATION	14	6s. DECEDEN	T'O HOUAL	OCCUPATION	201		Lee				WILLE	
E	(Specify only Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5		(Give kind life. Do NO	of work do	ne during mo	st of working	ng	186.	KIND OF BUS	SINESS/IND	USTRY		
COMPLETED	12	(12)	College (1-4 or 5	"			chni			-	Busin	ess M	achi	nes	
Š	17. FATHER'S NAME (First, M	liddle, Lasi)						18. MOT	HER'S NA	ME (First, M	iddle, Maiden	Sumame)			
BE 0	Philip Fra	ncis V	Vhelan							et Wh					
10	19s. INFORMANT'S NAME (7	,,									er, City or Town				
-	Paula A.		1		422	3 Eve	erett	Stre	eet,	Kens	ingto	n, MD	20	0895	
	20a. METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	comoto	LACE AND DA	a other pine	and .			DATE		CATION C			
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		Sucre / f	Gat	e of	Heave	en Cer				5 Sil	ver S	prin	ng,Maryland	
	-1//	//	1//	110	/	22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc							Inc.		
	1//1/1	16	1/ill	ell	á	15	OU Ur	niver	sity	y Blv	d.W. S	Sil.S	pr.M	D 20901	
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heart failure. List only one cause on each line.												Approximate interval Between		
	IMMEDIATE CAUSE (Final												: Interval Between		
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	disease or condition	→			Respi		n Pne	umor	nia				_	Onsat and Daath	
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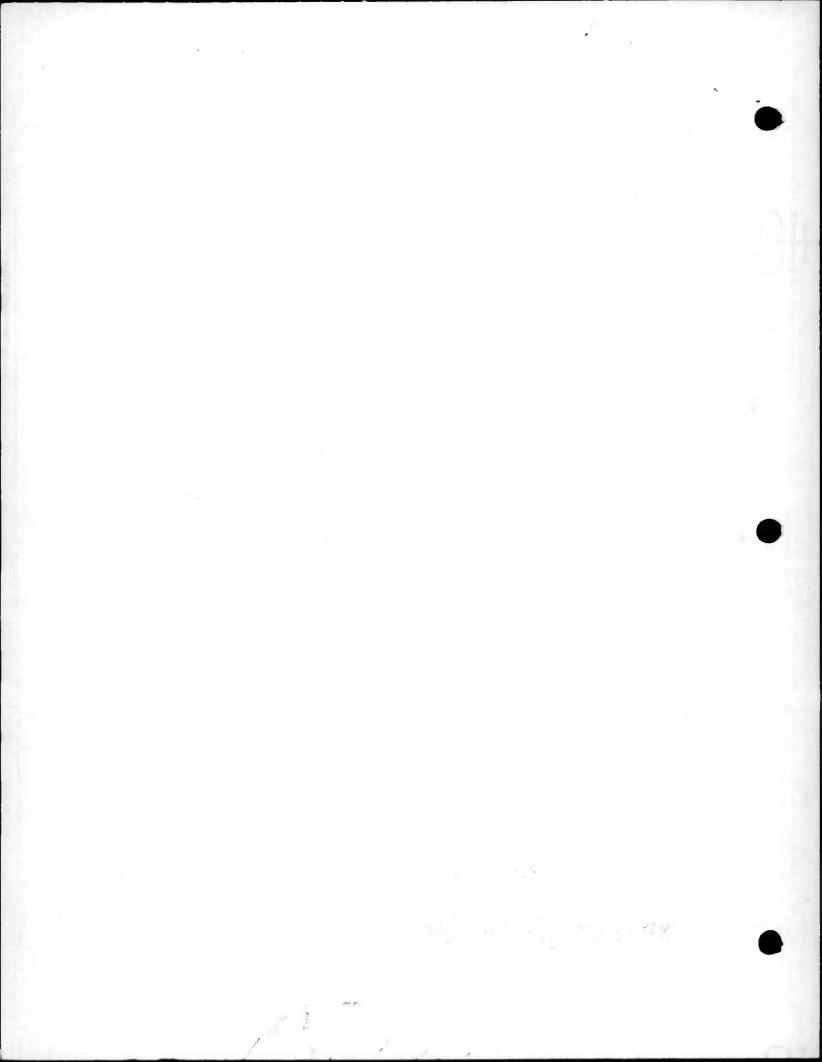
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			1. DECEDENT'S NAME (First, Middle, Leat) Warren	W.	Waldron,	Jr.	1.	2. DATE OF DEATH MONTH 19	199	3. TIME OF DEATH 9:45 A N
	Pi	DIRECTOR	4. SOCIAL SECURITY NUMBER 577-38-9279	1 🔀 M 2 🗆 F	GE (In yrs. last birthday	MONTHS DAYS	HOURS MIN	7. DATE OF BIRTH (Morth, Day, Year) Tuly 3, 19		BIRTHPLACE (State or Foreign Country) ennsylvania
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ısıt permit. Pages 1,	it. Pages 1		10e. STATE 10b. COUNT	gomery		ckville	TION			10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗌 NO
	FUNERAL	4807 Eades Stree	t		10	1. ZIP CODE 20853		10g. CITIZEN	USA	
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5	nse	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1.2		(Give kind o	s usual occupation of work done during mouse retired.)	ON osl of working	16b. KIND OF BU		
YLAND 2	d be detached for	ш	17. FATHER'S NAME (First, Middle, Lest) Warren W. Waldron		Lingi	neer	16. MOTHER'S NAME Dorothy	E (First, Middle, Maiden		Planning Comm
, MAR be retained	be notified	TO B	190. INFORMANT'S NAME (Type/Print) Annie Laura Waldr	on			eet, Rock			
Page 6 may be r	director, pa		20e. METHOD OF DISPOSITION 1 🖾 Burlel 2 🗆 Cremetion 3 🗆 Rem 4 🗆 Donation 5 🗀 Other (Specify)	or Town, State , Maryland						
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32 REGISTRAR'S CONSTURE



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH REDA JEAN WARRENER April 27 9:35 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR 7. DATE OF BIRTH 215-34-0094 1 M 2 X 58 YRS March 19, Virginia 1937 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Baltimore 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 744 Edmondson Ave. 21228 the burial-transit U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 10 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: White the funeral director, page 5 should be detached for use as 8 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Щ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Housewife Domestic notified at once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname Hurley Powers Nancy Collins 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Donald Warrener, Jr. 14503 Thornton Rd., Sparks, MD 21152 Pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) Stablers Cemetery Parkton, 1995 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 cremation, or removal the medical 23. PART I/Enter the/diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, the attending physician and completely filled in by it Mental Hygiene prior to burial, cremation, or remo Approximate shock, of heert fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition olon event. resulting in deeth) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF traumatic CERTIFICATION Sequentisity list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause, Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initisted events reaulting in death) LAST 0 Injury, PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE has been signed by the Dept. of Health and I shows any 1 TYES 2 NO DF OEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) DIRECTOR: After this certificate hours after death with the State OTHER 1 - YES 2 - NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF OEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 2 Accident м 1 YES 2 NO В 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 80 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be item 28 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner es stated. TO THE FUNERAL I be filed within 72 h IMPORTANT: If It of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mor 포프 2 PLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) N. Charles



1995

9c. COUNTY OF OEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

Specify

U.S.A.

14. RACE — American Indian, Black, White, atc.

White

3. TIME OF DEATH

0230

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

t 🗌 YES 2 ី NO

N. Carolina

REG. NO

6

2. DATE OF DEATH

APRIL

BALTIMORE, MARYLAND 21215-0020

tmendel.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

JAMES

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5. SEX 7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 MONTHS DAYS 1 XM 2 F YAS 241-24-1720 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR University of Maryland Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Washington Hagerstown permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE bunal-transit 148 Plantation Drive 21740 Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the bunial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. MARITAL STATUS t 🗌 Never Married 2 💢 Married 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced W.W. II ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 0 Master Plumber Plumbing Contractor 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Herbert Wood BE Bessie Barefoot 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Otsy M. Wood 148 Plantation Dr. þ 20b. PLACE AND OATE OF DISPOSITION (Name of DATE must funeral director, Germantown Baptist Church 4-8-95 Germantown, Maryland 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 24 hours after death. 415 E. Wilson Blvd. Hagerstown, Md. 21740 the medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory errest, filled in by shock, or heert feliure. List pniy pna cause on each line. 6 **IMMEDIATE CAUSE (Finel** the cremation, disease or condition and completely fi burial, cremation CARONARY ARTERY DISEASE reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): IDIOPATHIC PULMONARY FIBROSIS and CERTIFICATION Sequantially list conditions, 2 DUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate cause. Enter UNDERLYING physician phor PROSTATE CANCER death certificate CAUSE (Disease or injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initiated events the attending p resulting in deeth) LAST 6 Injury, PART II. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the Health and any 1 YES 2 NO shows a peen 5 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square has be Dept. PHYSICIAN: UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate the the State **EXAMINER?** HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Rasidenca 8 □ Other (Specify) 1 - YES 2 - XO 1 Inpatient 2 ER/Outpetient 3 DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED this (marked, INJURY 1 X Netural 1 YES 2 NO ВҰ After 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 69 8 Could not be DIRECTOR: A COMPLETED 28 4 Homicide If Item 29a. CERTIFIER 1 CERTIFYING PHYRICIAN: To the beat of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. THE FUNERAL [filed within 72 h TO THE FUNERAL be filed within 72 IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SKEWATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 뿔 BE RESIDENT 2 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22. S. GREENE ST BALTIMORE, MD 21201 NDRE MYERS 32. REGISTRAR'S SIGNATURE

Edward WOOD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Hagerstown, Maryland 21740 20c. LOCATION — City or Town, State Approximata interval Between Onaet and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 - NO 29d. DATE SIGNED (Month, Day, Year) DHMH-16 Rev 1/89

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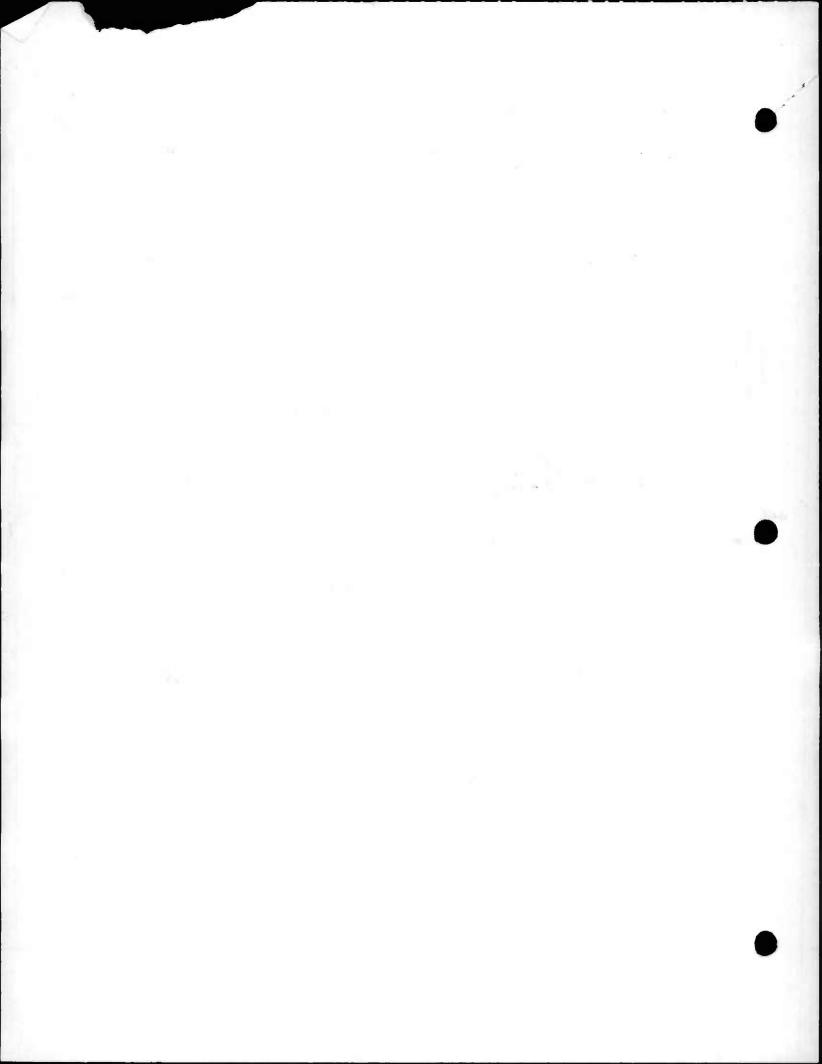
_	1 - STATE REGISTRAR	STATE OF MARY		EPARTMEN RTIFICAT			D MENTA	AL HYGIEI		•		
3	1. DECEDENT'S NAME (First, Middle, Last MARY L	Mar WILLIAMS	y Loui	se Wil	liams	S	MON	e of DEATH		YEAR	3. TIME OF DEATH 12: 10 P. M	
	4. SOCIAL SECURITY NUMBER 220-18-0603	1 □ M 2 対 F 70	(In yrs. last bli	YRS. F UNDI	DAYS	IF UNDER 24 HR	S 7 DATE	of BIRTN		Country)	LACE (State or Foreign	
стов	98. FACILITY NAME (If not institution, give 16735 Hampton Robeston Residence of decedent					nsport	F DEATN		Washi			
DIREC	Maryland Washington Williamsport									10d. INSIDE CITY LIMITS? 1 ☐ YES 2 🍱 NO		
FUNERAL	16735 Hampton R	oad									HAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	D 13	If yes, sp	ENDENT OF HIS ecity Cuben, Me 2 NO Sp	PANIC ORIG xican, Puerto ecily:	N? (Specify Ye Rican, etc.)	ee or No— t		American Indian, White, etc.	
APLETED	15. DECEDENT'S ED (Specify only highest grac Elementery/Secondary (0-12) 12 years	UCATION le completed) College (1-4 or 5+)	(Give I	DENT'S USUAL (kind of work done NOT use retired.	during mo	est of working	16		aft Mf			
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Clarence E.	Brewer				18. MOTNER'S Haz	_	Middle, Maider		Fors	sythe	
10	190. INFORMANT'S NAME (Type/Print) Samuel G. Willia	ms				nd Number or Ru 1 Road					nd 21795	
	20s. METHOD OF DISPOSITION 1 Burisl 2 Cremetton 3 Removel from State 4 Donetton 5 Other (Specify)											
	22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North hagerst											
	23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										Approximata Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL O	PART II. Other significant condition	ilting in tha u	nderiying	g cause given	in Part I.	24a. WAS AP PERFO 1 YES	RMED?	â	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO			
SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			YES T		UNCERT	AIN 🗆					
PHYSIC	1 🗆 YES 2 🖵 NO 27. MANNER OF DEATN	HOSPITAL: 1 Inpatient 2 ER/Out		DOA 4 Nu	aing Hom	e 5 Residen	_		INJURY OCCUR	RED		
ED BY	1	28a PLACE OF INJURY	f — At home,	М	1 🗆 1	rES 2 NO	28f. LOI	ATION (Street or Town, State	and Number or	Rural Rou	ite Number,	
COMPLETE	29e. CERTIFIER (Check only	SICIAN: To the best of my know ER: On the basis of examination					due to the ca	use(a) and ma	inner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIE			/ 41	3	29c. LICENSE I		and place, a			Aonth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WI	no completed cause of de ody 1190 Mt.	Aetna	(Type, Print) a Road	Hag	erstown	/5 8 n, Mar	yland	21740)	785	

22 SEGISTR S SANGURE

35-74 of 3A, and application

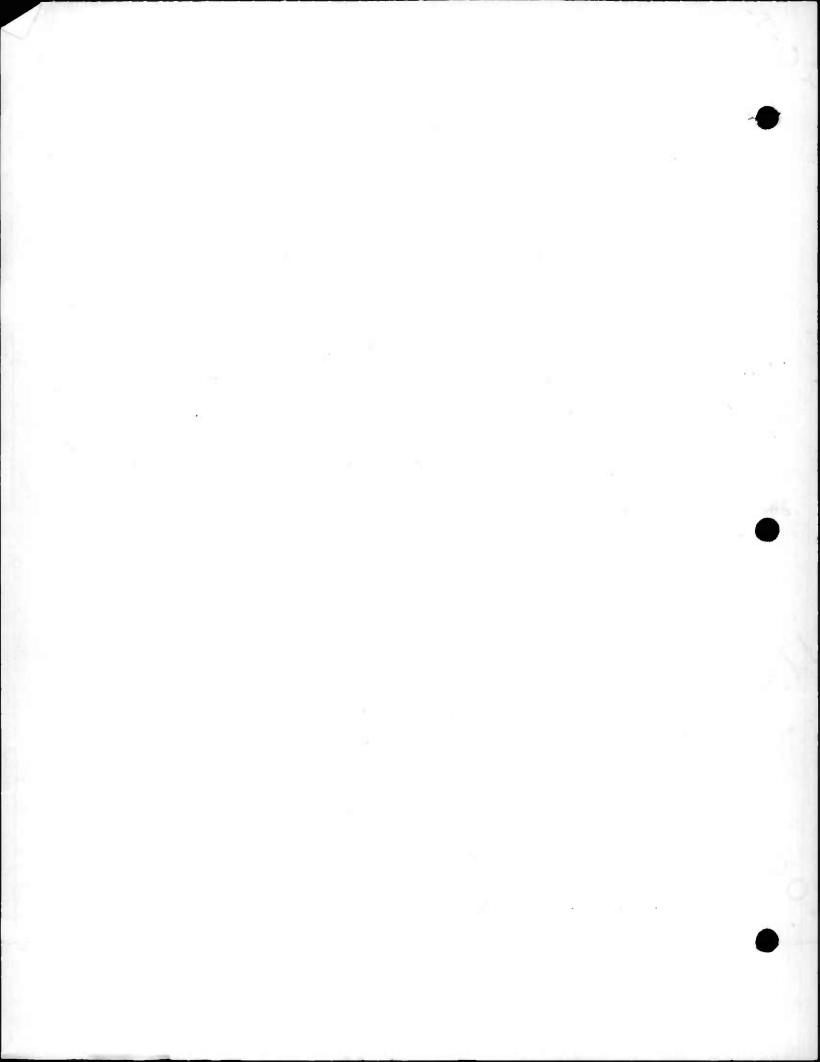
DIVISION OF VITAL RECORDS, P.O. BOX 68760, SALTIMORE, MARYLAND	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	TO T	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPC
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF H	EALTH AND DEATH	MENTAL	HYGIEN	E	10004		
	19490 C	" WHAALC	L'yman Wh	C. ittaker		2. DATE	OF DEATH	7 Q	3 342		
	4. SOCIAL SECURITY HUMBER 220-30-1365	M2 DF	YRS.	YRS. MONTHS DAYS HOURS MIN.					Massachusetts		
TOR	99. FACILITY NAME (If not institution, give Anne Arundel Marce of December 1		9		PRIOCATION OF D	DEATH /	′	9c, COUNTY OF OEATH Anne Arunde I			
DIRECTOR	MD Ani	ne Arundel	10c. CITY, 1	OWN OR LOCAT	apolis	_	_	10d. INSIDE CITY LIMITS? 1 YES 2 NO			
VERAL	100. STREET AND NUMBER 1656 Chinford	Γrail		101	ZIP COOE 214	01		10g. CITIZEN OF WHAT COUNTRY? United States			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR OA	2 NO	If yes, sp	ENOENT OF HISPA Helfy Cuben, Maxle 2 NO Specia	an, Puarto R	? (Specify Yea lican, alc.)	or No 14	. RACE — American Indian, Black, White, atc. Specify: White		
PLETED	15. OECEOENT'S E (Specify only highest gri Elementary/Secondary (0-12)		18a. DECEOENT'S US (Give kind of work life. Do NOT use n	k done during mo etired.)				iness/indus			
COMPL	17. FATHER'S NAME (First, Middle, Last)		Capta	111	18, MOTHER'S NA				Arriy		
BEC	William Whittal	ker					Tryon	,			
10 8	190. INFORMANT'S NAME (Type/Print) Gertrude M. Wh	ittaker	19b. MAILING AC 1656 C	oness (Street a	d Trail	Annap	er, City or Town	ND 214	401		
	20a. METHOO OF OISPOSITION 1 Burlel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	emoval from Stata ceme	PLACE AND DATE OF elery, crematory or other	Cemeter	v 4/1	8/95	Ann	anoli	or Town, State		
	21. SIGNATURE OF CHINERAL BERVICE	De la companya della companya della companya de la companya della		22. NAME AN	D AOORESS OF FA	Joh	n M.	Taylor	Funeral Home napolis, MD		
	IMMEDIATE CAUSE (Fine) disease or condition	e. List pny one cause on ea	the death. Do not ich line.	entar the mo	de of dyling, auc	ch aa cardi	iac Dr reapi	ratory arreat	t, Approximete Interval Between Onset and Death		
2	resulting in death) a. DIE TO (OR AS A CONSEQUENCE OF):										
RTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CALISE (Diseases taking)										
CERTIF	CAUSE (Disease or injury that initiated eventa resulting in death) LAST C. OUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other eignificent conditions for the work of		at not reaulting in t	the underlying	cause given in		24a. WAS AN PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	DID TOBACCO USE CON				UNCERTAI	Ν□					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:							
2	1 TYES 2 NO	28a, DATE OF INJURY	28b. TIME O		5 Residence						
- 1	Natural 5 Pending	Month, Day, Year)	DM	Y WO	RK?	Lol	16	IJURY OCCUR	ieo		
D 84	2 Accident Investigatio 3 Suicide 8 Could not be	28s. PLACE OF INJURY	- At home, farm, stre			281. LOCA	TION (Street a		Rural Route Number,		
<u> </u>	4 Homicide determined	building, atc. (Speci	"Home	_		City o	r Town, State)				
COMPLEIE		YSICIAN: To the best of my knowledge. NER: On the basis of examination							suse(s) and mannar as stated.		
	296. SIGNATURE AND TITLE OF CERTIF				29c. LICENSE NUI				SNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON V	WHO COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri		11/14	()		- 41	7) [7]		
	31. DATE FILEO (Month, Day, Maer)	Pel, Anna 32. REGISTRAR'S SIGNA	polis, we	1 2/	401						
	APR 1 9 1995	Julia Deviler	-								



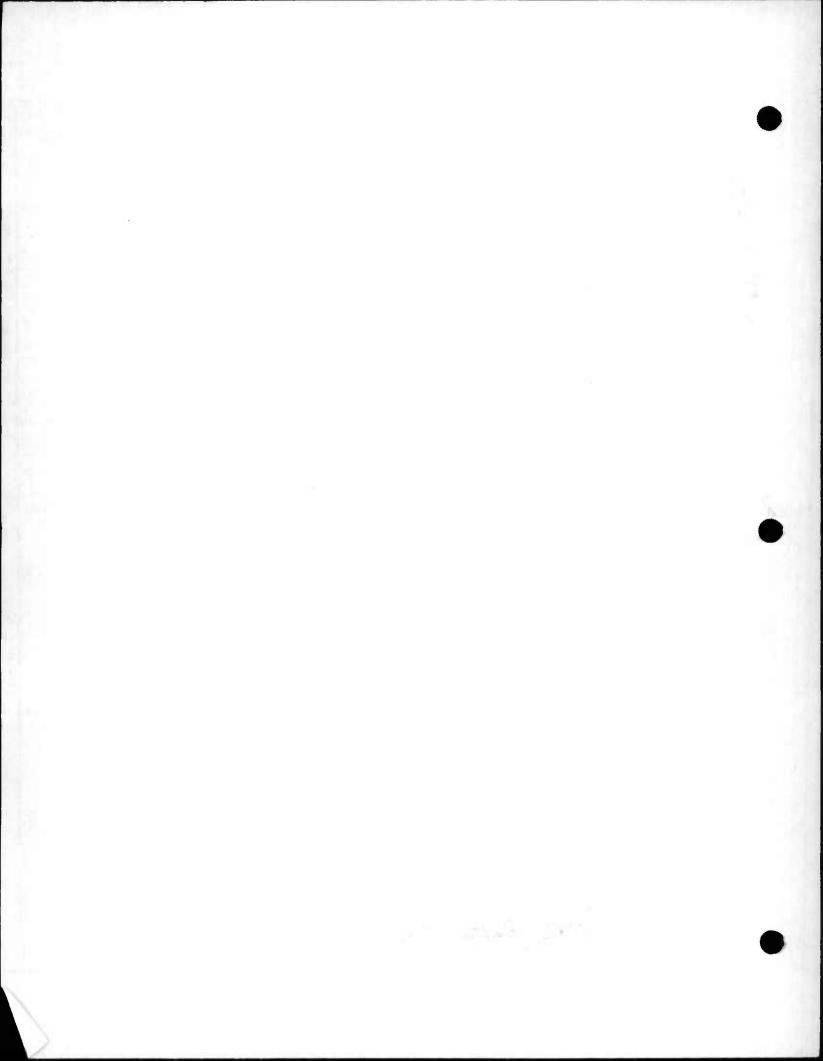
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	and appropriate proposed at the contract of th
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	lase:											9,	J	13303
	1 - STATE REGISTRAR		STATE OF I	MARYLA			MENT OF			MENT	AL HYGIEN	E		
()	1. DECEDENT'S NAME (Firs	t, Middle, Last)											3. TIME OF DEATH	
			anche N	lovale	ee	Wa	lton				pr 11 199			3:45PM
9	4. SOCIAL SECURITY NUM 206-12-0319	BER	5. SEX	6. AGE (In	yrs. lest b		IF UNDER 1 YES		DER 24 HRS. S MIN.	7. DAT	E OF BIRTH off, Day, Year) 8-25	8. BIRTHP Country)	ACE (State or Foreign	
į	9a. FACILITY NAME (# not in	nstitution, give s			70		9b. CITY, TOV	VN OR LOCA	LOCATION OF DEATH 9c. COUNTY OF DEATH					
DIRECTOR	Calvert Ma		rsing Ho	me_			Rising Sun					Cecil		
E	RESIDENCE OF DE		10c. CITY.						10d. INSIDE CITY					
DH	PA		_	TY, TOWN OR LOCATION KFORD						- 1	LIMITS?			
RAL	PA Chester 100. STREET AND NUMBER					_	101. ZIP CODE					t0g. CITIZ		AT COUNTRY?
CNEH	901 Catam	ount R	d.					193	63			US	SA	
5	11. MARITAL STATUS 1 Never Merried 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARME		13. WAS	DECENDENT	T OF HISPAI	NIC ORIG	ilN? (Specify Yee o Rican, etc.)	or No-	14. RACE - Black,	- American Indian, White, etc.
5	3 🔀 Widowed 4 🗌 Dive		IF YES, GIVE V	MAR OR DAT	res			YES 2 X N					Specify	White
3	15. DEC (Specify on	EDENT'S EDU	CATION completed)				SUAL OCCUP		dring	16	Sb. KIND OF BUS	INESS/IND	USTRY	
7 6	Elamentary/Secondary (0-12) College (1-4 or 5+)					o NOT use	work done during most of working use relired.) Farmer Agric					lture		
COMPL	17. FATHER'S NAME (First, Middle, Lest)							ts. Mc	OTHER'S NA	ME (First,	Middle, Maiden			
ш	Cecil F	letche	r								neffiel	,		
9 2	190. INFORMANT'S NAME (19b. I						mber, City or Town			
-	Sandra					A	rbour	Cour	t Not	ting	gham, P.	A 193	362	
	20 METHOD OF DISPOSIT 1 Burlel 2 Cremelic 4 Donation 5 Other	On 3 Rem	oval from Stata				DISPOSITION (place)		0277	DA I	1–95 Ru	CATION — C	Ity or Tow	n, State
-	21. SIGNATURE OF FUNERA	рар	_											
-	· Todward Han						22 NAME AND ADDRESS COTTINS Funeral Home, Inc. 86 Pine St. Oxford, PA 19363							
CERTIFICATION	disease Dr condition resulting in death) a. METASTATIC CARCINOMA OF BREAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
. 1	resulting in deeth) LAST													
MEDICAL		PART II. Other significent conditions contributing to deeth but not result HYPERTENSION FRACTURE												VERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? VES 2 NO
	DID TOBACCO U		RIBUTE TO CA	USE OF	DEATH	H YES	□ NO	M UN	ICERTAI	И П				
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			- 0	(Check only o	nne)						
1 3	1 YES 2 NO		1 Inpatient 2 I				Nursing i		Rasidence					
- 4	1 Natural 5	Pending	(Month, D		ľ	INJUR	₹Y	INJURY AT WORK?	□ №	28d. DE	EŞCRIBE HOW IN	IJURY OCC	URED	
ים מי	3 Suicide 8	Could not be determined	28e. PLACE O building,	F INJURY — atc. (Specify	- Al home	, farm, atro					CATION (Street ar	nd Number (or Aural Ro	ute Number,
COMPLETED	(Check only		CIAN: To the beat of R: On the basic of e											and manner as stated.
BEC	29b. SIGNATURE AND TITLE	OF CERTIFIER	16.0	1/100	Am	8 10	-1	29c. L	ICENSE NUM	BER		29d. DATE	SIGNED (Month, Day, Year)
9 0 1			XJULL	user	0100	100	7)	1	453	44		•	4/121	195
	30. NAME AND ADDRESS OF	HAN V	3 43	E OF BEAT	H (ITEM 2	A I Co	rint)	RN	PER	RVV	ILLE 1	40 2	1902	
	31. DATE FILED (Month, Day,		ali Music	R'S SIGNAT	Lall	11 01	UPVIV	100	1.071	, , ,	1 = 50/-	101	1102	
	WILTI.	1	2010		-									



		1 - FOR STATE REGISTRAR	STATE OF MARY	/LAND	/ DEPART	MENT OF	HEALTH AND	MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) Myrtle Marie YATI						2. DAT MON Ap	ril 15	, 1995	YEAR 3.	3:00 p.
permit. Pages 1, 2, 3 should		4. SOCIAL SECURITY NUMBER 245-07-4462	1 M 2 M F	75		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	E OF BIRTH		BIRTHPL Country)	C . '
	CTOR	9a. FACILITY NAME (If not institution, give 11204 Pepperbush RESIDENCE OF DECEDENT			9		or Location of D gerstown			9c. COUNT		ngton
	DIREC	10a. STATE 10b. COUNT	nington			agerst						d. INSIDE CITY LIMITS?
Si.	FUNERAL	100. STREET AND NUMBER 11204 Pepperbush	Circle			10	Or. ZIP CODE	40			N OF WHA	T COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 2 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	S 2 2	ARMED NO	If yes, s	CENDENT OF HISPA pecify Cuban, Mexico S 2 3 NO Specific	en, Puerto		or No—	Black, W Specify:	American Indian, hita, alc.
2121 al or atte for use	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)		Give kind at wor ife. Do NOT use i	k done durina m	ION ost of working	16	b. KIND OF BUS	her o		ome
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.	BE CON	17. FATHER'S NAME (First, Middle, Last) J. T. Twiddy					Alice			Surname)		
E, MAR or stained to page 5 should be notified	10	John H. Yates					and Number or Rural Springs]					21783
MORE, I age 6 may be director, page 5 or must be n		20s. METHOD OF DISPOSITION TO Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of configure, clematory, or other place). Cedar Lawn Memorial Park 4-19-95 Hagerstow.										
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.		> CONTI	Min	ne	if	MINN	ICH FUNE E.Wilson	RAL		erstow	n.Md	21740
hin 24 hours at tely filled in by mation, or remot, the medical		IMMEDIATE CAUSE (Final	complications that cause of List only one cause of a. Cancer of Due to (or A.	of th	na. ne lung	entar the m	oda of dying, auc	h as ca	rdiac or reapi	retory arres	t,	Approximate Interval Between Onset and Deat
o.O. BO certificate be nding physicia Hygiene prior or other trau	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b									
RECORDS, P w requires that the death been signed by the atten pt. of Health and Mental I shows any Injury, o	MEDICAL C	PART II. Other significant condition	na contributing to death	but not	resulting in	tha underlyln	ng cause given in	Part I.	24a. WAS AN PERFOR 1 TYES 2	MED?	CO DF	RE AUTOPSY FINDINGS IILABLE PRIOR TO MPLETION OF CAUSE DEATH?
- a 8 8 8 1	SICIAN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE		ATH YES	7		N 🗆			1	YES 2 NO
EVIT ICIAN: TI Sertificate the State	IYSIC	EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/O	utpatient	3 🗆 DOA 4	THER:	ne 5 🗆 Residence					
NG PHYS frer this ceath with	ВУ РНУ	1 Natural 5 Pending 2 Accident Proventigation	(Month, Day, Year	")	28b. TIME C	M t 🗆	JURY AT ORK? YES 2 NO	26d. DE	SCRIBE HOW II	NJURY OCCU	RED	
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is mai	ETED	3 Suicide 8 Could not be 4 Homicide detarmined	26a. PLACE OF INJU building, atc. (S	RY — At I	noma, farm, stre	el, factory, offic	ea .	26f. LO	CATION (Street a or Town, State)	nd Number or	Rural Route	Number
로 보었는	COMPL		ICIAN: To the best of my known. ER: On the besis of axemina									d manner ea stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	O BE C	296, SIGNATURE AND TITLE OF CERTIFIE	11 Wester	wh			29c. LICENSE NUI		6		18/9	nth, Day, Year)
		30. NAME AND ADDRESS OF PERSON WH Dr. Howard N. We					Ave., Ha	gers	town,	Marvla	and 2	1742

1 - FOR STATE REGISTRAR



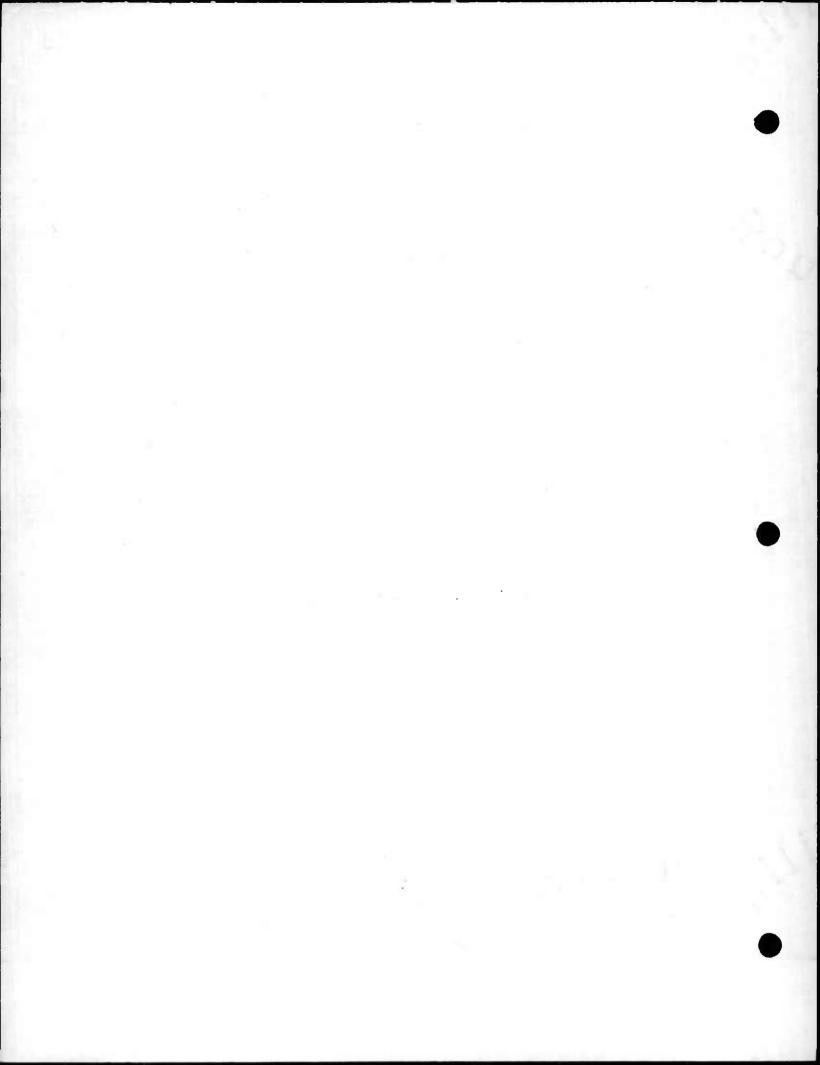
-	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYG	IENE
	REGISTRAR	CERTIFICATE OF DEATH REG	NO.

		HEGISTRAR			C	EKIIF	ICALE	OF DEATH	REG. N	Ю.		
		1. DECEDENT'S NAME (First	, Middle, Last)				-		2. DATE OF DEATH		3.	TIME OF DEATH
	1	Joseph A. A	lagna	Jr.					монти 5	DAY 2	YEAR	7:35 P M
		4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. las	A b feet et						
							MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		BIRTHPL. Country)	ACE (State or Foreign
2		213-20-4119		1 € M 2 □ F	69	YRS.			(Month, Day, Year)	5	Mary	land
pinous		9e. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CITY, TOV	WN OR LOCATION OF D	EATH	9c. COUN	TY OF DEAT	гн
60	E I	VA Medical	Contor	•			Balti	mara		37 / 7		
.2	١Ķ١	RESIDENCE OF DEC	CEDENT				Daili	more		N/A		
S	DIRECTOR	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN OR LO	CATION			100	od. INSIDE CITY
Pages	1 5	1470	37/3								- 1	LIMITS?
permit.		MD	N/A			Ba	ltimor	e			1.	YES 2 NO
	ERAL	10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZ	EN OF WHA	T COUNTRY?
risit	6	338 South (Oldham	Street				21224		US	A	
020 physician. burial-transit	FUN	11. MARITAL STATUS		12. WAS DECEDER	NT EVER IN U.S. AF	MED	13 WAS	DECENDENT OF HISPA	NIC ORIGIN2 (Specific			American Indian.
20 gr 15 S		1 Never Married 2	Merried	FORCES?	MAR OR DATES	OP	If yes	, specify Cuban, Mexico	nn, Puerto Rican, atc.)	100 01 110-	Black, V	/hite, etc.
the the	₩	3 Widowed 4 Dive	become	IF YES, GIVE	MAR OR DATES		10	YES 2 XNO Specif	fy:		Specify:	
215-0 attending se as the	9	44 000		WWII								White
	밑	(Specify onl	EDENT'S EDUC y highest grade	completed)	(G	ive kind of v	USUAL OCCUP	ATION most of working	16b. KIND OF I	SUSINESS/IND	USTRY	
ND 21 hospital or ached for u	핔	Elementary/Secondary (0	0-12)	College (1-4 or 5	Min	. Do NOT us	e retired.)					
<u>©</u> 👼 🖸	릴	11th	2		S	upplu	Super	visor	Trop.	hu		
YLAND by the hospit be detached at once.	COMPL	17. FATHER'S NAME (First, M	liddle, Last)						AME (First, Middle, Meid			
YLA by the be det	Ŏ	The state of the s										
A Para	H	Joseph All		laqna Sr.					es Culott			
retained 5 should	2	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stre	eet end Number or Rural	Route Number, City or 1	own, State, Zip	Code)	
2 2 2	F	JoAnne M .	Valcor	irt		338	S. 010	lham St.,	Balto. M	ת 2122	4	
ay be		20e. METHOD OF DISPOSIT			205 81 405							
ORE e 6 may lector, pag		1 D Burlel 2 - Crematic	on 3 🗆 Reme	oval from State	cemetery, cre	metory or of	oF OISPOSITION	(Neme of	DATE 20c.	LOCATION C	ity or Town,	State
2 2 2		4 1 Donation 5 - Other			New	Cath		Cemetery		Balto.	,MD	
ALTIMOR death. Page 6 ma thneral director, p. i. examiner must		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE				E AND ADDRESS OF FA				
ALTI death. P funeral		▶ ('Y . V	. 1	1 1	0		Cha	rles S. Z	eiler & S	on Inc	•	
		. Ohon	an I	- Jew			622	4 Eastern	Ave., Ba.	lto.,	MD	
S after s after the the the the the the the the the the		23. PART i. Enter the d	isessea, or c	omplications the	it caused the de	ath. Do n	ot entar tha	mode of dying, suc	ch as cardiac or res	piretory arre	est.	Approximate
5 = 9		shock, or h	eart lanure.	List only one cer	ise on each line).	-					Intarval Between
filled ion. or	1 1	IMMEDIATE CAUSE (Fir disease or condition	nei	1/2.7	L. 1		7.1	00 +				Onset end Death
the stely mat		resulting in death)	→ ,	vanu	ricula		In	llaleur	/			
ompleteh or crema		1		OUE TO	(OR AS A CONSE	DUENCE OF	7:	lation gan F	0 1			
2000	z			Trus	Oficest	am	01	an 3	alles	0		
and to but	0	Sequentielly list conditi	ions,	DUE TO	(OR AS A CONSE	DUENCE OF):	year.	mui	~		
a ciai a	4	if any, leading to imme- cause. Enter UNDERLY					,	U				į
certificate ding physical physical physical certificate principle physical certificate physicate physical certific	ERTIFICATION	CAUSE (Disesse or Inju		DUE TO	/00 40 4 00H0F							
S Se Se Se Se Se Se Se Se Se Se Se Se Se	Ē	that initiated events resulting in death) LAS		DUE 10	(OR AS A CONSE	JUENCE OF);					ļ 1
T = 8 = 0	H H	resulting in death, LAS		d								
D.S., P. ne death the atten Mental H. njury, or	ᇰ											
THDS, that the dear by the att the and Menta any injury, any injury,	4	PART II. Other significa	nt condition	s contributing to	deeth but not	sulting j	n the underly	ying cause given in	Part I. 24a. WAS	AN AUTOPSY		RE AUTOPSY FINDINGS
	0	cons	Vote	ne He	ut I	ail	use			ORMED?		AILABLE PRIOR TO IMPLETION OF CAUSE
signed Health am	EDICAL		0	1					1 _ YES	2 NO		DEATH?
requires been signe of Healt	2									/	1 (YES 2 NO
	Ë	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S NO	UNCERTAIL	N 🗆			
AL he law he bept e Dept	¥.	25. WAS CASE REFERRED TO	O MEDICAL		26. PLAC	E OF DEAT	H (Check only o	nne)				
SICIAN: The certificate h the State I	SICIAN:	EXAMINER?		HOSPITAL:	Teno	7.00.	OTHER:					
CLA!	Σ̈́	27. MANNER OF DEATH		1 Sinpatient 2				iome 5 - Residence	8 Other (Specify)			
ON OF VITA ONG PHYSICIAN: The After this certificate hadeath with the State D smarked, or item:	РНҮ	_/		28e. DATE OF (Month, D		26b. TIME		INJURY AT WORK?	28d. DESCRIBE HOV	INJURY OCC	URED	
NG PHYS frer this eath with	B		Pending Investigation				0.0	YES 2 NO				
After death		3 Sudates	_	28e. PLACE C	F INJURY At ho	me, term, s	treet, fectory, o	ffice	28f. LOCATION (Street	t and Number (or Rumi Boute	Alumbar
5 5 6 8	ED .		Could not be determined	building,	atc. (Specify)				City or Town, Ste	te)	a ridren riddie	, Nomber,
3 2 E	ET	and the same of										
240 g 5 8	COMPL	29e. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	sth occurre	d at the time, d	late end place, end dua	to the cause(s) and m	enner es state	d	
HOSPITAL FUNERAL ATT: II	Σ							n, death occured at the				4
FUNER WITHIN	8	- freeze							mile; date alle place;	and due to the	causa(s) an	d member as stated.
POR POR	m	296. SIGNATURE AND TITLE	OF-CERTIFIER	00				29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Mo	onth, Day, Yhar)
TO THE HOSPIT TO THE FUNER De filed within	8	va	NH	lleu	TU			1142/	15	1 5	-5-	95
0=	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH (ITE	1 27) (Type	Print)	1 100				, ,
- 1 m		Love K	110.	unh	10.11	24-	200	L KNT		12	200	,
741		-013 111		101	IUNG	KE	الاعمر	F. BALTIA	10REM	DAI	201	
		31. DATE FILED (Month, Day.	Your)	3 REGISTRA	THE RIGHT THE							
	- 4	MANU IN MAILIE										
		MAY 0 8 19	של כנ									

31. DATE FILED (Month, Day, Year)
MAY 0 8 1995

32. REGISTRAR'S SIGNATURE

							20	10300
	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME CERTIFICA	NT OF H	EALTH AND I	MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last)	Laurae 7	Ha A.	An	denin	2. DATE OF DEATH		3. TIME OF DEATH 5'23A
	4. SOCIAL SECURITY NUMBER 215-22-76-40		yrs. lest birthday) IF UN MONTH	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	916	BIRTHPLACE (State or Foreign Country)
TOR	11. 1 1 11	street and number)	96.0	TY, TOWN OF	Bu n	EATH /	9c. OQUNT	ne Arunde
DIRECTOR	10a. STATE Hd 10b. COUNT HD	ne Arunde	10c. CITY, TOW	N OR LOCATIO	3um 1+	è		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 7575 8. +	toward 1	ld	101.	ZIP CODE	1	10g. CITIZE	N OF WHAT COUNTRY?
B≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	It yes, spec	NDENT OF NISPAN city Cuban, Mexica 2 (17 NO Specify	NIC ORIGIN? (Specify Yon, Puarlo Rican, etc.)	os or No— 14	RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL (Give kind of work do the Do NOT use retire	ne during most	of working	16b, KIND OF BI	JSINESS/INDUS	f md
BE COM	Tay (0: 7	Carey		1000	18. MOTHER'S NA	ME (First, Middle, Maide	n Surname)	
TO B	Telishia	Little	19b. MAILING ADDR	ESS (Street and		Route Number, City or To	wn, State, Zip Co	Burne, nd
	20e METNOD OF OISPOSITION Burlel 2 Cremetlon 3 Rem Donation 5 Other (Specify)	center center	PLACE AND DATE OF DISP tery, cremetory or other place ON ON		Cen.	SATE 20c. L	Sa (y or Town, State to, md
	21. SIGNATURE OF FUNERAL SERVICE LIN	DENSEE DOT		March	ADORESS OF FA	West Wash 1	me. 6	Bo 140 Md 21215
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that ceused List only one cause on as	the death. Do not en	ter the mod	e of dying, such	h as cerdisc or resp	piratory arres	t, Approximata Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	Hypertensiv		ccular	Discass	^		Onset and Deat
	resulting in death)	8	CONSEQUENCE OF):	SCUIUL	Discus			
z		Congestive :	Heart Fail	ure				İ
임	Sequentially list conditiona, If any, leading to immediate	· ·	CONSEQUENCE OF):					
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	. Atrial Fibr						
CERTIFICATION	that initieted events		CONSEQUENCE OF):					
<u> </u>	Todaling in duality Exot	_{d.} Hypothyroidi	sm					
MEDICAL (Old Cerebrovasc		t not resulting in tha	underlying	ceuse given in	Part I. 24a. WAS AI PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YES	NO E	UNCERTAIN			1 YES 2 NO
Ž	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF OEATN (Che		JITCERIAII	,		
Sic	1 Tes 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpet	OTH Something the state of th		5 🗆 Residence	8 Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH 1 N Natural 5 Periding	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJUI WOR	RY AT	28d. DESCRIBE NOW	INJURY OCCUP	ED
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY – building, atc. (Specif)	At home, farm, street, f		S 2 NO	28f. LOCATION (Street		Rural Route Number,
	4 Nomicide determined					City or Town, Stell		
COMPLETED		CIAN: To the best of my knowled R: On the basis of examination						ause(s) and manner as stated.
BEC	250 SIGNATURE AND TUTLE OF SERTIFIE		721		29c. LICENSE NUN			IGNEO (Month, Day, Year)
2	M. NAME AND ADDRESS OF PERSON WH	ttending	Physician)) ,	D14160)	▶ 05/	05/95
	Hariit Singh. M		H (ITEM 27) (Type, Print) Ritchie Hic	Thr. 737.7	Paltim	omo Ma o	1225	



TO THE HOSPITAL WATER DATE THE LAW SIGNAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

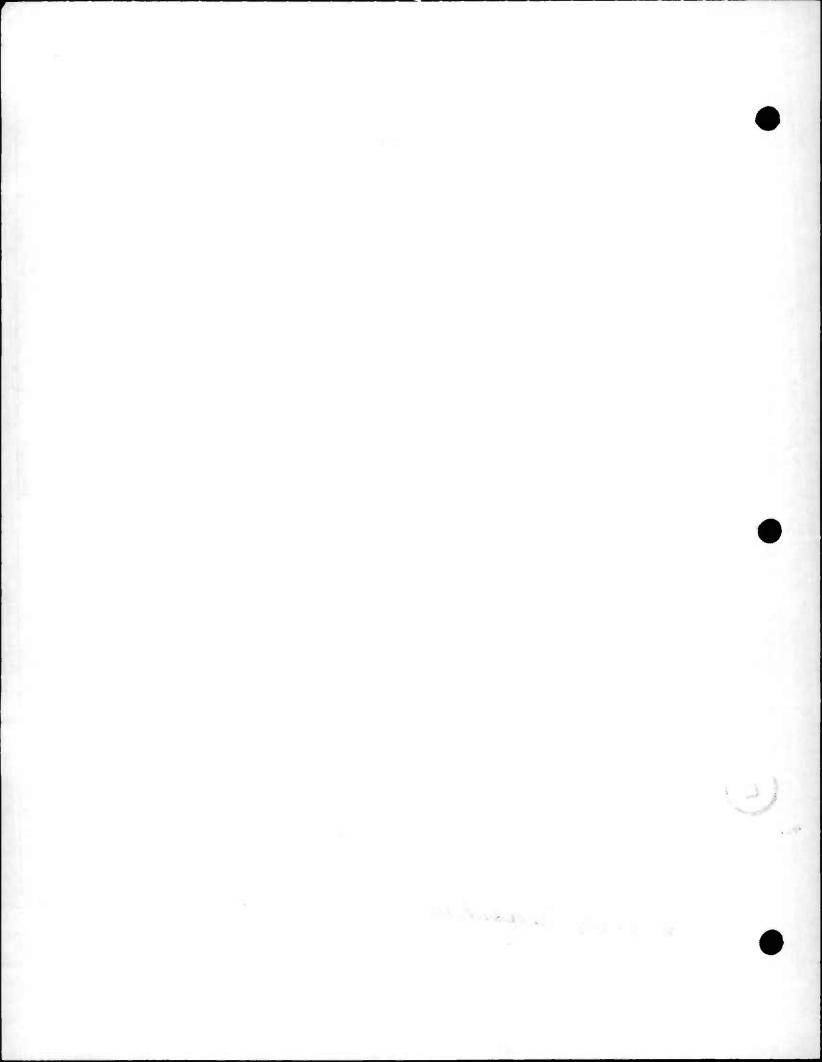
TO THE FUNERAL DESCRIPTAMENT the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after certificate beath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 22 that many or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 O. BOX 68760

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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF H	EALTH AND DEATH		GIENE 3. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		3. TIME OF DEATH
	GARFIELD	ALLENDER	SR.			MAY 3	. 1995	YEAR	6:30 a · M
	4. SOCIAL SECURITY NUMBER 217-12-3333	5. SEX 6. AGE (In		UNDER † YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR	TH	8. BIRTH Country	PLACE (State or Foreign MARYLAND
	9a. FACILITY NAME (If not institution, give s	treet and number)	9b.	CITY, TOWN C	R LOCATION OF D	EATH	9c. COUN		EATH
СТОР	THE JOHNS HOPKIN				ORE CITY		- I	I/A	
FUNERAL DIRECTOR	MARYLAND 106. COUNTY	Ň/A	BAL	TIMOR	E E				10d. INSIDE CITY
VERAL	1225 N. POTOM	AAC STREET		101	21213		U.S		HAT COUNTRY?
В	11. MARITAL STATUS 1 Never Married 2 Amerried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, spe	ENDENT OF HISPA ecify Cuben, Mexico 2 NO Special	NIC ORIGIN? (Specian, Puarto Rican, a	city Yes or No—	14. RACE Black Specia	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary(Secondary (0-12)	CATION completed) College (1-4 or 5+)	16e. DECEDENT'S USU (Give kind of work- life. Do NOT use ret TRUCK	done during mo: ired.)	st of working		OF BUSINESS/INDU		SINESS
BE CON	17. FATHER'S NAME (First, Middle, Lest) ERNEST ALLEND	DER			18. MOTHER'S NA MARI	ON SHA	Meiden Sumame)		
10 8	190. INFORMANT'S NAME (Type/Print) ESSIE ALLENDER	{	196. MAILING ADD 1225 IV	POTO	MAC ST	Route Number, City	or Town, State, Zip (Code) YLA	ND 21213
	20a. METHOD OF DISPOSITION 1 General 2 Generation 3 Remodel 4 Donation 5 Other (Specify)	oval from State 20b.F	PLACE AND DATE OF DI tery, crematory or other p				0c. LOCATION C	ity or To	
	21. SIGNATURE OF FUNERAL SERVICE CO	poties /		22. NAME AN	D ADDRESS OF FA	CILITY			
	no S	und					L2W.NOR		AVENUE
	IMMEDIATE CAUSE (Final	List only one cause on acc	rascular			ch aa cerdiac or	respiratory arre	st,	Approximate interval Between Onsat and Dasth
CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):						10 days
PHYSICIAN: MEDICAL C	PART II. Other elgrificant condition Hypernam		t not resulting in th	e undarlying	cause givan in	P	MS AN AUTOPSY ERFORMED? YES 2 NO		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N.	DID TOBACCO USE CONTE			Z ON [UNCERTAI	N 🗆			1 123 2 2 10
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	B. PLACE OF DEATH (C	heck only one) HER:					
14S	1 VES 2 NO 27. MANNER OF DEATH	1 1 Inpatient 2 ER/Output				8 Other (Specif	y) HOW INJURY OCCU		
	1 Natural 5 Pending	/Month One Markey	A N A	M 1 Y	RK?	N/		IRED	
тер ву	2 Accident Investigation 3 Suictde 6 Could not be determined	26a. PLACE OF INJURY — building, etc. (Specify	At home, ferm, street	, tactory, office			Street and Number of	r Aural A	oute Number,
COMPLETED		CIAN: To the best of my knowled R: On the basis of examination a					nd menner es stated		and manner as stated.
띪	296. SIGNATURE AND THE OF CENTIFIER	- 0			29c. LICENSE NUI	MBER			Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO					95	Bulhmo	re in	d 21205
	MAY 0 8 1995 Ju	in attention factor	OTHE			34.100	Ontilling		~ C: C-3



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

for HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 hr IMPORTANT: If It

296 SIGNATURE AND TITLE OF CERTIFIE

1995

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erance

BE

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATN 3. TIME OF DEATN May E 10:50 A 6. AGE (In yrs lest birthdey) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH 82 South 1 M 2 WF Pages 1, 2, 3 should 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR more 10b. COUNTY LOCATION 10d. INSIDE CITY mo 1 YES 2 NO permit. FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9 use as the burial-transit 0 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Maxican, Puerto Rican, etc.)
 U YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. APMED FORCES? 1 YES 2 YNO RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced α ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working the Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPL has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 0 notified at once. 17. FATNER'S NAME (First, Middle, Last MOTNER'S NAME (First BE 2 9 na injury, or other traumatic event, the medical examiner must be 20e. METNOD OF DISPOSITION
1 Burlel 2 Cremation 3 LACE AND DATE OF DISE 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 00 50 P.P .2121 WP 23. PART I s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory errest, Approximate shock, or heart Interval Between **IMMEDIATE CAUSE (Finei** Onset and Death disease or condition METABOLIC Acidorio recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): Cance PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditions, if any, leading to immediate SEPSIS . Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST -allure PART ii. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Va shows any 1 YES 2 W DE DEATN? rateru Fallure 1 | YES 2 | 100 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem DIRECTOR: After this certificate hours after death with the State HOSPIPAL:
1 I impatient 2 - ER/Outpatient 3 - DOA OTHER: 1 - YES 2 -10 ng Home 5 - Residence 8 - Other (Specify) marked, or 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Item 28 is COMPLETED 6 Could not be 4 Nomicide 29e. CERTIFIER viedge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. (Check only one) 2 MEDICAL EXAMINER tion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end π

WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Typ) Print)

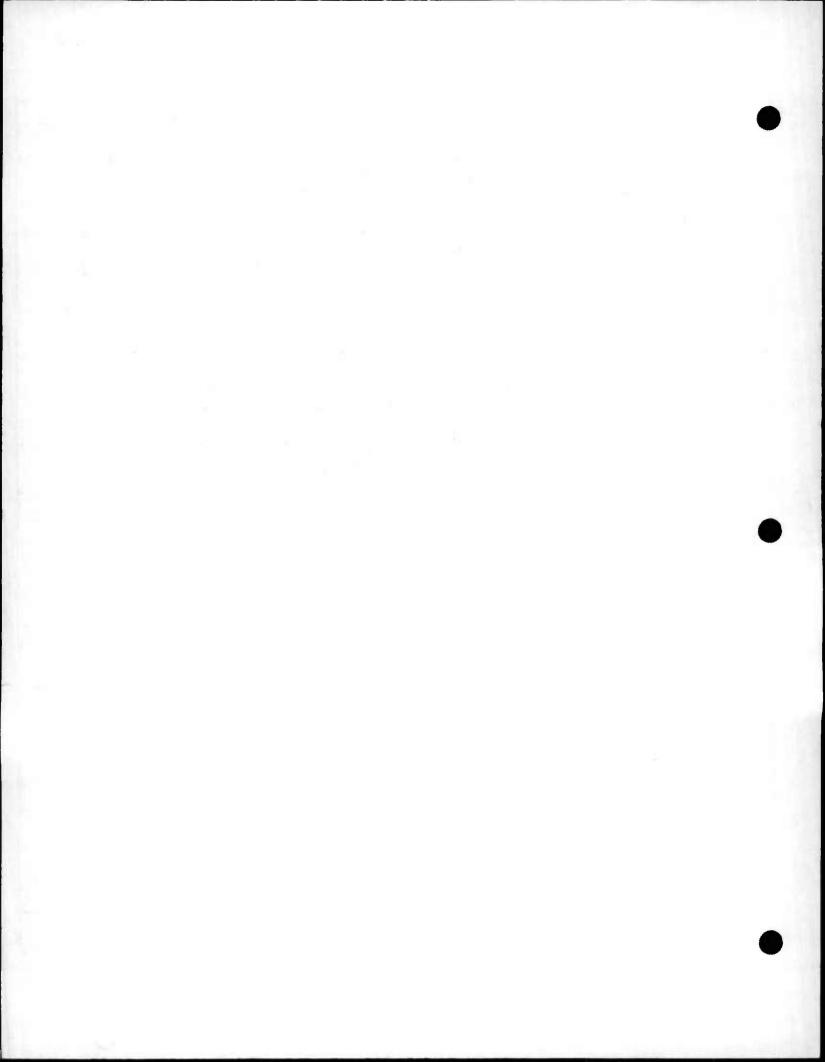
32. REGISTRAR'S SIGNATURE

chentz

mo alal

29d. DATE SIGNED (Month, Day, Year)

29c. LICENSE NUMBER



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	RTMENT OF H	EALTH AND	MENTAL HYGIEN REG. NO.	E	
	1	DECEDENT'S NAME (First, Middle, Linst LILLIAN	G	BROS	EKER		2. DATE OF DEATH MONTH DA		3. TIME OF DEATH 1:10 pm M
Pir	1	4. SOCIAL SECURITY NUMBER 217-07-9376	1 🗆 M 2 💢 F	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Voer)	6. Bif	ATTHPLACE (State or Foreign untry)
, 2, 3 should	ECTOR	9a. FACILITY NAME (If not Institution, give Saint Joseph Med RESIDENCE OF DECEDENT				on Location of or		9c. COUNTY OF	
permit, Pages 1,	DIR	10a. STATE 10b. COUN	ALTO.	10c. CIT	Y, TOWN OR LOCAL PETRY				10d. INSIDE CITY LIMITS? 1 YES 2 KNO
nsit	FUNERAL	100. STREET AND NUMBER A DUNHAVEN	Place 18	3	101	21234	۵.	10g. CITIZEN O	F WHAT COUNTRY?
215-0020 attending physician. ise as the burla-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	ecify Cuben, Mexica 2 NO Specifi	HC ORIGIN? (Specify Yes in, Puerto Rican, atc.) /:	81	ACE — American Indian, lack, White, etc. pecity:
D 21 spital or ed for u	COMPLETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	Give kind of life. Do NOT u		ON est of working	RETA		
3 E E	BE COI	17. FATHER'S NAME (First, Middle, Last)	TZ			18. MOTHER'S NA	ME (First, Middle, Meiden RA MILL)		etmann
be retain be 5 sho of 5 sho	T0		roseker	195. MAILING 250		and Number or Aural	Poute Number, City or Town	n, State, Zip Code)	21234
nector,		20a. METHOD OF DISPOSITION 1	noval from State ceme	PLACE AND DATE ery, cremetory or o PRKUCO	00		S/1199 Pa	CATION - City or	
SALTI r death. P ne funeral al. examin		21. SIGNATURE OF FUNERAL SERVICE L	Descriptions		850	0 HARF	of Memoria	es alto. M	
in 24 hours after ely filled in by the hation, or removal , the medical		23. PART i. Enter the diseases, prahock, or heert failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused to List only one cause on and PNEUMONA	the death. Do i	not enter the mo	da of dying, suc	h aa cardiac or respi	ratory arrest,	Approximata Interval Batween Onset and Death 7 DAYS
executed within and completely o burial, cremat matic event,	N		URINARY TRA		*				7 DAYS
an cian	ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	CHRONIC COL	VGESTIVI	HEART F	ALURE			4 YEARS
ath certificate trending physical Hygiene profession of the control of the contro	CERTIFI	that initiated eventa reaulting in deeth) LAST	d	ONSEQUENCE OF	ጉ ፡	9			
HECORDS, Preducts that the death seen signed by the attent of Health and Mental Ishows any Injury, o	MEDICAL C	PART II. Other aignificant condition	ns contributing to death but	not resulting	in the underlying	g ceuse given in	Part i. 24e. WAS AN PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Sept a	SICIAN: 1	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL			S NO	UNCERTAIN	N D		
SICIAN: The sertificate him the State E	YSIC	1 YES 2 NO	NOSPITAL:		OTHER:	e 5 🗆 Residence	8 Other (Specify)		
Service of the control of the contro	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM INJ	URY WO	URY AT RK? rES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED	
	ETED E	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify	At home, farm, s	street, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Rurs	al Route Number,
1246	PLE	29a. CERTIFIER (Check only	SICIAN: To the best of my knowled	ige, death occum	ed at the time, date	and place, and due	to the cause(s) and man	ner as stated.	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

NATIVIDAD D. DE LEON, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204

31. DATE FILED (Month, Day, Year)

MAY 0 8 1995

Jahr Discrete Filed (Month, Day, Year)

296. SIGNATURE AND TITLE OF CERTIFIER

No atting dad Dr de from

29d. DATE SIGNED (Month, Day, Year)

727,1995

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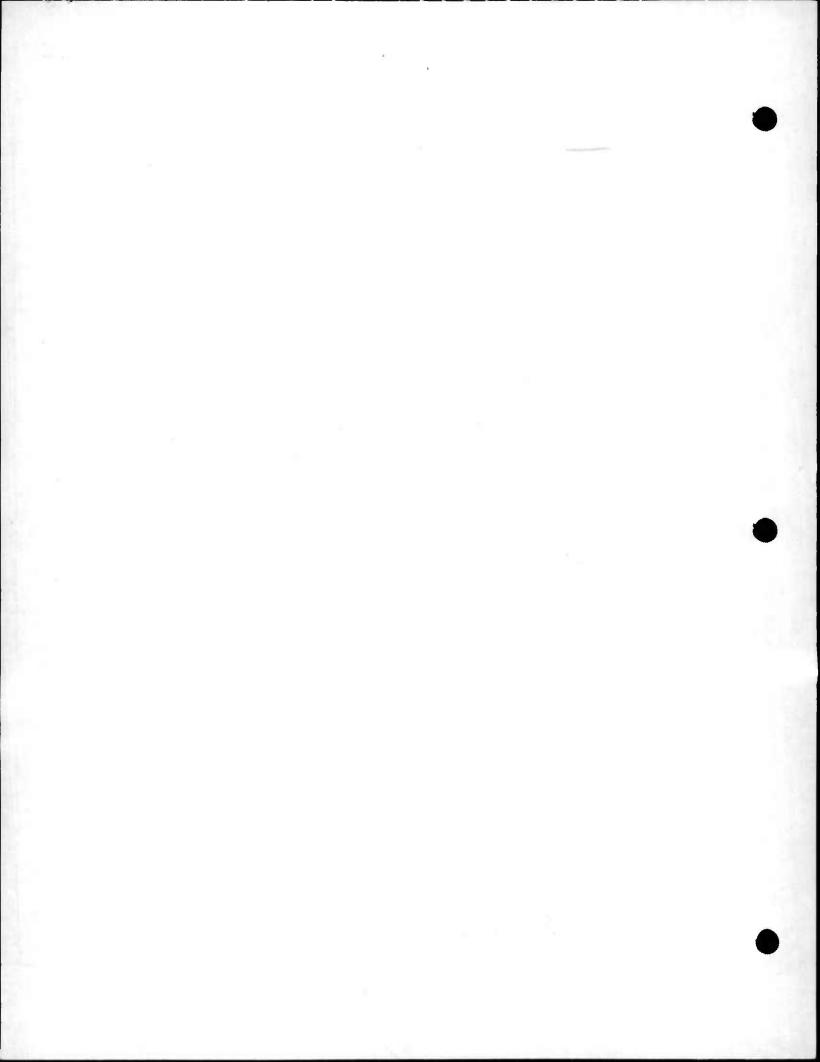
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HUSPITAL OF ALLENDING PHYSICIAN. THE JAW FEQUIPES THAT THE DEATH CERTIFICATE DE EXECUTED WITHING THE DOLD A TRENDING THE DOSPITAL OF ALLENDING THE D	ERA	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the second of th
5	E	With.	74.87
_	_	-	- 5

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CHARLES YEAR BALINT PPRIL 30 1995 10:30 A 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 11/24/17 151 09 5169 6. AGE (In yrs. last birthday IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS HOUSE 1 X M 2 | F 7 7 YRS. New York Se. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore City n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Anne Arundel Baltimore 1 - YES 2 1 NO FUNERAL 10a. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 201 Ninth Avenue 21225 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— It yes, specify Cuben, Mexicen, Puerto Ricen, stc.) 11. MARITAL STATUS 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR OATES 1 TES 2 TO NO Specify: BY 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) steel worker stee1 vears Vears 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) Charles S. Balint Mary Bordash BE netified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 201 9th Ave. Baltimore Md. 21225 Mildred C Ralint 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must 1 Burtal 2 Cremation 4 Donation 8 Other (Specify) Burtal 2 Cremation 3 Removal from State tery, cremetory or other plece) 5/3/95 Baltimore Md. 21225 Holy 22. NAME AND ADDRESS OF FACILITY examiner 21. SIGNATURE OF FUNERAL SERVICE LICEN 4001 Ritchie Hwy. Baltimore Md. nedical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart fellure. Liet only one ceuse on each line. Intarvai Between Onset and Death IMMEDIATE CAUSE (Final he disease or condition nemite resulting in death) DUE TO (OR AS CERTIFICATION Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CO thet initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? elevalex any 1 TYES 2 TO NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 5 Rasidence 6 Other (Specify) 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify) 26t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 69 COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER TO THE DE filed : 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 30, 1995 dd/1 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 54110LO PREPERICE RD MD DAMIAN

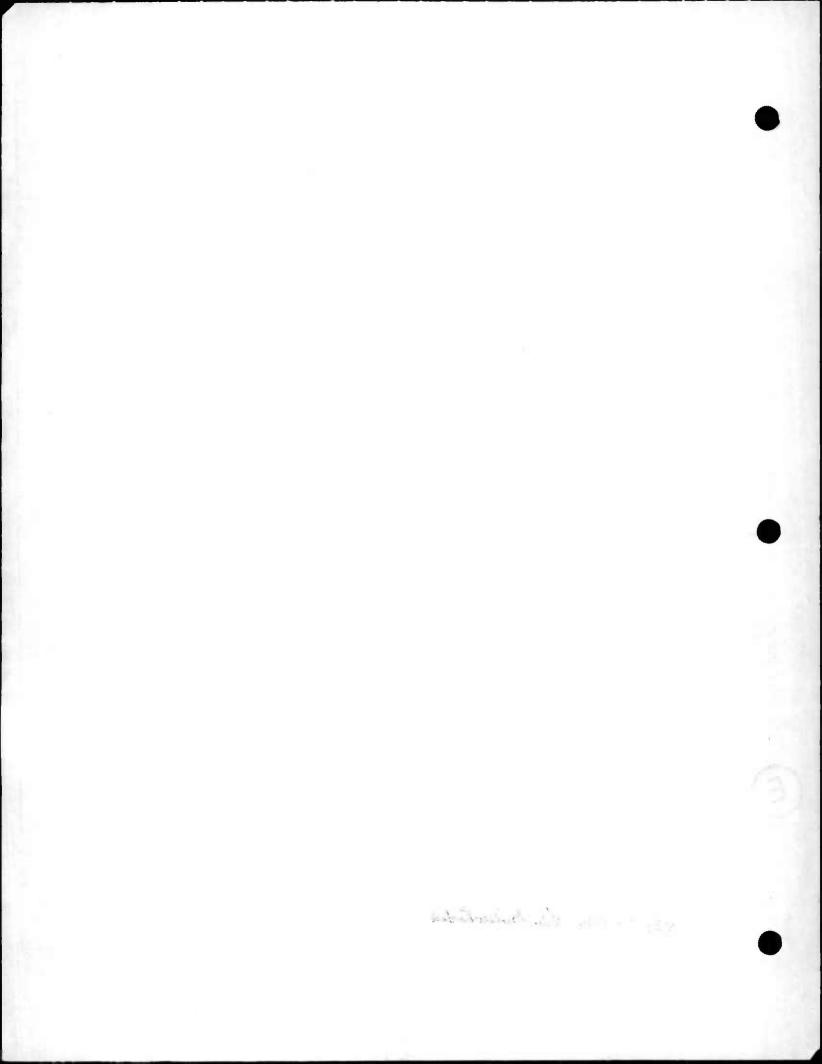


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

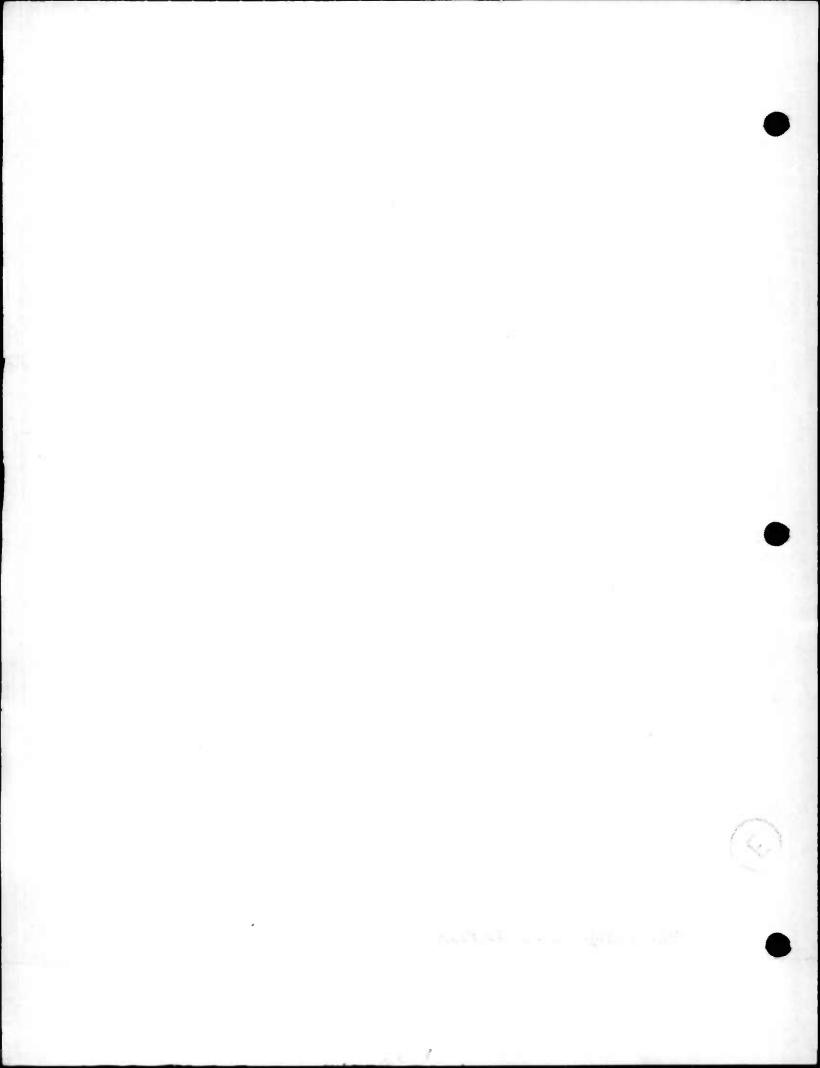
0100 C1313 CNIVI (1110 CNIVI)	TO THE HOSPITAL OF TELEGRAPHICE IN THE LAW requires that the death certificate be executed within 5 hours after death. Page 6 may be retained by the hospital or attending physicis	TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to-filled within 72 hours after death with the State Deat, of Health and Mental Hunison prior to burial cremation or removal	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	executed wi	n and comple	matic ever
	certificate be	ling physiciar	other trau
	the death	y the attend	Injury, or
	requires that	sen signed b	shows any
	IN: The law	State Dept.	item 23
,	R PHYSICIA	er this certi	narked, or
	PERM	IRECTOR: After	m 28 is n
	HOSPITAL 0	UNERAL DI	ANT: If ite
	TO THE	TO THE F	IMPORT

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH BARNES				2. DATE OF DEATH BAY 4 28	3 3 3 S	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 214-12-9511	1 🔀 M 2 🗆 F	9 6 YRS. MON	NDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MHN.	7. DATE OF BIRTH (Month, Day, Year) 12 22 1898	8. BIRTHPL	2:15 PM ACE (State or Foreign CH CAROLII
TOR	90. FACILITY NAME (If not institution, give str IRVINGTON KNOLL RESIDENCE OF DECEDENT	set end number) S NURSING	CENTER **	BALTIMORE		N/A	
DIRECTOR	MARYLAND 106, COUNTY	N/A		NN OR LOCATION FIMORE			Od. INSIDE CITY LIMITS? YES 2 NO
IERAL	1628 GWYNN FALI	LS PARKWAY		10f. ZIP COOE 21217	10g.	U.S.	AT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DATE	2√□NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Speci		Black, \	- American Indian, White, atc. BLACK
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16e. DECEOENT'S USUI (Give kind of work of life. Do NOT use reti	one during most of working ed.)	166. KINO OF BUSINESS		
BE CON	17. FATHER'S NAME (First, Middle, Last) JOSEPH BARNES	3		18. MOTHER'S N. REBE(ME (First, Middle, Meiden Surnan	10)	
TO B	190. INFORMANT'S NAME (Type/Print) FLORENCE BARNI	ES	19b. MAILING ADD 2121 V	RESS (Street end Number or Rural VINDSOR GARI	Acute Number, City or Town, Statu EN LANE BAI	Zip Code)	E MARYLAN
	20e. ETHOD OF DISPOSITION 1	val from State ceme	PLACE AND DATE OF DIS tery, crematory or other pi	POSITION (Name of ace) MT. ZION	5-3 BALTIA	I — City or Town	, Stata
0.000	21. SIGNATURE OF PUNERIAL SERVICE LICE	INSEE ISAC		22. NAME AND ADDRESS OF FI IRVIN CARRO	OLL 1712 W.F	ORTH.	AVENUE
CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heart failure. Limited in the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A C	CONSEQUENCE OF):	gnery o	Mses se Mis dusphs		Approximate Interval Between Onset and Daath
PHYSICIAN: MEDICAL CERTIF	that initiated events resulting in death) LAST d.		CONSEQUENCE OF): t not resulting in the	undariying cause given in	Part I. 24a. WAS AN AUTOP PERFORMED? 1 UYES 2 NO	OF OF	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
IAN: N	DID TOBACCO USE CONTR		DEATH YES		ΝÃ	1	TYES 24E NO
YSIC	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpat	tient 3 DOA 4	1€R: Nursing Home 5 □ Residence	8 Other (Specify)		
ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	/ A 28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY	OCCURED	
	Accident Investigation Suicide 8 Could not be determined	28s. PLACE OF INJURY - building, atc. (Specif	At home, farm, streel,	fectory, office N/A	281. LOCATION (Street and Num City or Town, Stete)	nber or Rural Rout	te Number,
COMPLETED					to the ceuse(e) end manner as time, data end place, end due i		nd manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	6674777	Amg Phy	29c, LICENSE NU		DATE SIGNED (M	
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print)		HVE BEIT	nymo	21215
	31. MAY 0 (108 1995)	of today of and	*				



it, the medical examiner must be notified at once	IMPORTANT TIEM 22 is married, or them 23 shows any injury, or other transmitted event, the medical examiner must be notified at once
itely filled in by the funeral director, page 5 should be detache mation, or removal.	TO THE PURIOR DESCRIPE After this certificial has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled early compared to the compared of the compared
hin 24 hours after death. Page 6 may be retained by the hosp	TO THE PROPERTY OF METERGINA PHYSICIAN. The Lie requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp
BALTIMORE, MARYLANE	AVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE STATE CERTIFICATE OF DEATH REG, NO.	
	1. DECEDENT'S NAME (First, Middle, Lent) B. Brophy. 2. DATE OF DEATH MONTH DAY YEAR 0.25	0 4
	4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Forest Months) Days (Month, Day, Year) (Month, Day, Year)	gn
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	_
TOR	B Manny tratth Car of Bottime Baltime City BALTIMORE CIT	Y
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?	
	MARYLAND BALTIMORE CITY BALTIMORE 100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY?	0
FUNERAL	15 18 W. Pratt St 21223 U.S.A.	
BY	11. MARITAL STATUS 1	
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY	
COMPLETED	9TH GRADE TRUCK DRIVER TRUCKING	
00	17. FATHER'S NAME (First, Middle, Lest) JOHN LEROY BROPHY 18. MOTHER'S NAME (First, Middle, Melden Surname) MARGARET CATHERINE COOK	
TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	\dashv
-	MRS. LINDA ZORNES 8423 ARBUTUS ROAD - PASADENA, MD 21122 209. METHOD OF DISPOSITION 200. PLACE AND OATE OF DISPOSITION (Name of DATE 200. LOCATION - City of Town. Steta	_
	20s. METHOD OF DISPOSITION 1\(\Lambda\) Burisl 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE ANO OATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY 5/10 GLEN BURNIE, MD	-
}	21. SIGNATURE ON FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE MD 21229	
_	23 PADT (First the diseases or complications that could be death Burning in 1977)	
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metaytate Small Cell Curnmen & Lux Metaytate	veen
NOI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):	
CERTIFICATION	CAUSE (Disease or Injury	
ERTI	that initiated events resulting in death) LAST	
	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FIND	INGS
EDICAL	PERFORMED AMILABLE PRIOR TO COMPLETION OF CAU DF DEATH?	SE
PHYSICIAN: ME	NO NO NO	
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:	
HYS	1 Inpetient 2 ER/Outpetient 3 ODA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNES OF CEATH 28s. OATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED	_
BY P	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO	
	3 Suicide 4 Homicide Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Yown, State)	
COMPLETE	29a. CERTIFIER (Check only one) 1 OFFITIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, dash occurred at the ilme, data and placa, and due to the cause(a) and menner as stated.	ıd.
BE	29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Dey, Year)	\neg
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	\dashv
	16 Hunter Cope and My 5310 Old wit Road Suite 201 Kanga Istaw MO 21133	_
	MAY U & 1995 july a distribution of the state of the stat	- {



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 😭 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely illed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.	ther traumatic event, the
THE HOSPITAL DR A	THE FUNERAL DIRECTOR THE THE THE THE THE THE THE THE THE THE	MPORTANT: If item 28

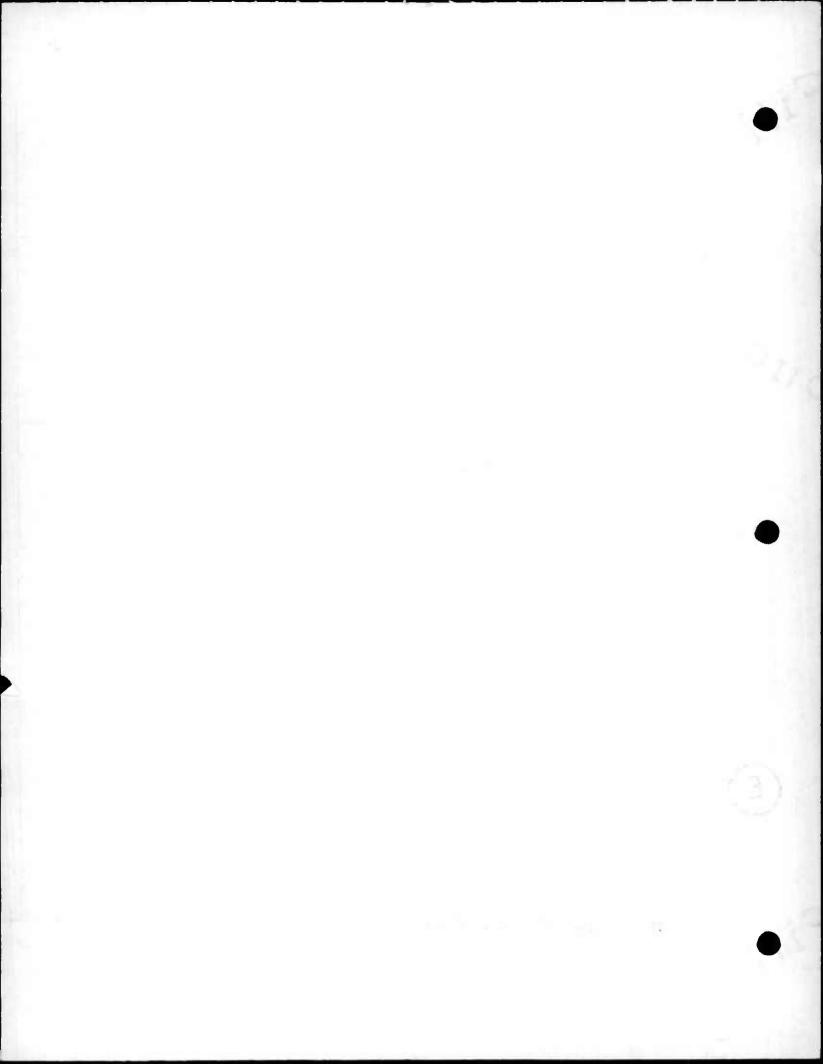
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) VERNA BATC	HELDE	R.		2. DATE O	F DEATH BY	1993	3. TIME OF DEATN 5 P. M		
9	261-32-1473 10 M2 DF	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year)	Co.	TTNPLACE (State or Foreign untry) eorgia		
TOR	9a. FACILITY NAME (If not institution, give street and number) Lorien Nursing Home RESIDENCE OF DECEMENT		96. CITY, TOWN	Howar						
DIREC	Maryland Anne Arundel	10c. Cf1	ry, town or loca	rion urel		10d. INSIDE CITY LIMITS? 1 □ YES X □ NO				
RAL	10e. STREET AND NUMBER		10	1. ZIP CODE 20724			F WHAT COUNTRY?			
BY FUNERAL DIRECTOR	243 Federalsburg South 11. MARITAL STATUS 1 Never Married 2 XX Married 3 Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 [I FYES, GIVE WAS DECEDENT FORCES FOR FORCES FOR FORCES FOR FORCES FOR FOR FORCES FOR FOR FOR FOR FOR FOR FOR FOR FOR FOR	EVER IN U.S. ARMED YES 2XX NO R OR DATES	13. WAS DEC	81	ACE — American Indian, ack, White, atc.					
COMPLETED E	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of	USUAL OCCUPATI work done during me se retired.)	ON ost of working	16b.	KIND OF BUSIN	NESS/INDUSTRY			
MPL	12 Ø	Homer	maker			Home				
	17. FATHER'S NAME (First, Middle, Last) George Chambers			18. MOTNER'S NA Edith Ha		ddle, Malden Su	imame)			
TO BE	19a. INFORMANT'S NAME (Type/Print) Richard Batchelder	19b. MAILING	ADDRESS (Street o	and Number or Rural				77.01		
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE	OF DISPOSITION (N		DATE		land 20			
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Baltimore-Wa	ashington		5/7		l, Maryl			
	1 (alales de	abou		on Sandy S		leck Fun Road, La	meral Hom nurel, Ma	ne, Inc. ryland 20707		
	23. PART i. Enjer the diseesea, or complications that ahock, or heart fallure. List only one cause	on each line.	not enter the mo	de of dying, suc	h as cardi	ec or reapire	tory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	C SHOOL	SIPA	EUMO	NIA			Onset and Beath		
N	Sequentially list conditions,	DRIDDE	DEN STATE.							
CATIC	If any, leading to immediate cause. Enter UNDERLYING	OR AS A CONSEQUENCE O	ARXIN	SHOOT.	DIS	ZAS	E			
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	ALZHEII	FES .	DISE	SE	,				
CAL	PART II. Other algoliticent conditions contributing to d	leath but not resulting	in the underlyin	g ceuse given in		24a. WAS AN AL PERFORMI 1 YES 2	ED?	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?		
PHYSICIAN: MEDI	DID TODACCO LISE CONTRIBUTE TO CAL	ICE OF DEATH W		1	_			1 TES 2 NO		
CIAN	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEA	TH (Check only one)	UNCERTAIN	<u>и П Т</u>					
1YSI		ER/Outpatlant 3 DOA		e 5 Raaldenca						
	1 Netural 5 Pending (Month, Day 2 Accident Investigation		JURY WO	VES 2 NO	28d. DESC	RIBE NOW INJ	URY OCCURED			
28a PLACE OF IN HIRY — At home form effect feelen; effect								el Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of m 2 MEDICAL EXAMINER: On the best of axe							e(s) and manner as stated.		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER ROYS 4	\mathcal{D} .		29c. LICENSE NUN	IBER 44	2	Pad. DATE SIGNI	ED (Month, Day, Year) 4 1995		
F	30. NAME AND ADDRESS OF PERSON WAS COMPLETED CAUSE FRANK CROSS MI	OF DEATH (ITEM 27) (Type)	Print) N. (OLLOCB	A	ND	210	15-11		
	31. DATE FILED (Month, Day, Year) 1995	's signature								

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3 20 5520

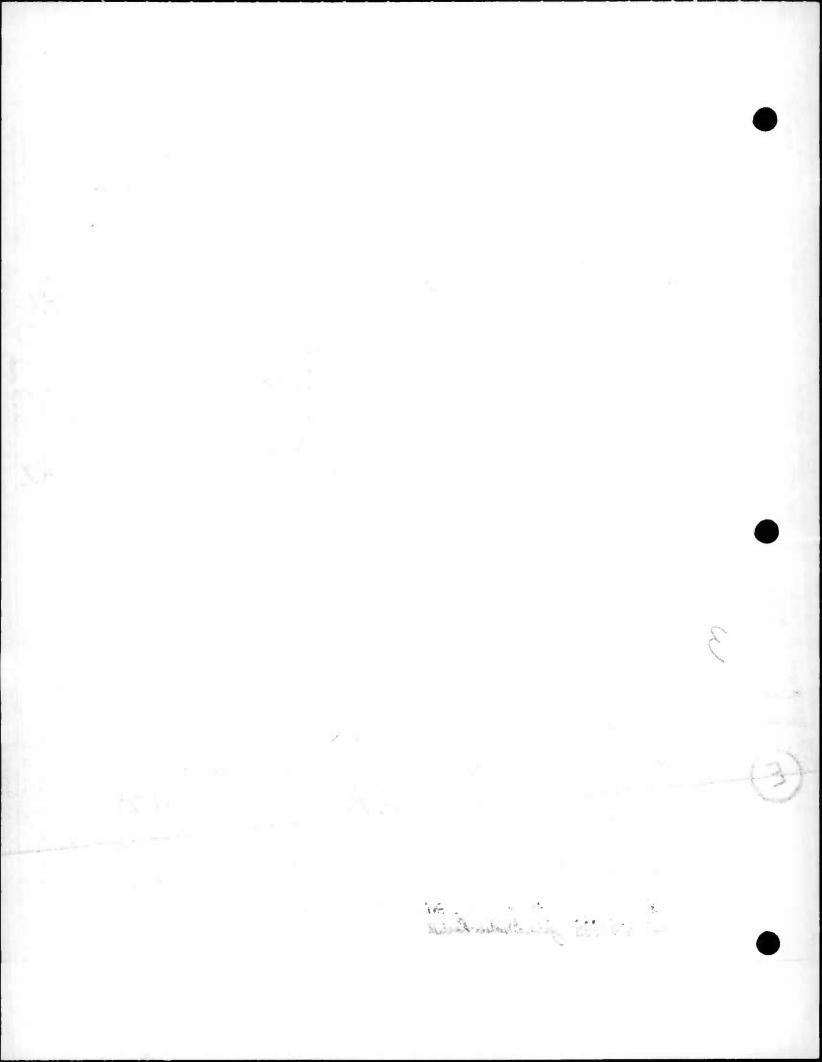
BALTIMORE, MARYLAND 21215-0020	eath certificate be executed within = Nours after death. Page 6 may be retained by the hospital or attending physician.	attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans
000	within a ho	pletely filled
(6876	executed	and com
, P.O. BOX 68760	eath certificate be	attending physician and completely filled in by the

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIFI	TMENT OF H	HEALTH AND		IYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) Kenneth R. Chris	tley				2. DATE OF MONTH		YEAR	3:40 P
P		4. SOCIAL SECURITY NUMBER 212-76-3894	120X M 2 □ F 36	n yrs. lest birthday) 6 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, Da MAY 31	y, Year)	. BIRTHPLAC Country) Maryla	CE (State or Foreign
i, 2, 3 should	TOR	99. FACILITY NAME (# not institution, give s Perry Point VAMC RESIDENCE OF DECEDENT	ireet end number)		Perry	Point	EATH	9c. COUNT Ceci	Y OF DEATH	
nit. Pages	DIRECTOR	Maryland Cecil		10c. CITY	, TOWN OR LOCAT	Port De	eposit			. INSIDE CITY LIMITS?] YES 2 X NO
an. ransit perm	FUNERAL	10 Sandy Brook Di	rive		101	2190 L ZIP CODE		- 20	USA	COUNTRY?
15-0020 ending physician. as the burtal-transit permit. Pages 1,	B≺	11. MARITAL STATUS 1X Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAN OR DATE 1975—1976	U.S. ARMED 2 NO TES	if yes, sp	ENDENT OF HISPA ecity Cuban, Mexico 2 M NO Specia	nn, Puerto Ricer		Black, Wh	American Indian, lite, etc. White
212	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elemantary/Secondary (0-12)	College (1-4 or 5 +)	18a. DECEDENT'S (Give kind of wife). Do NOT use	ork done during ma	ON ist of working		D OF BUSINESS/INDU		
AND the hospital detached i	COMPL	17. FATHER'S NAME (First, Middle, Lest)	2 10	JUUK		18. MOTHER'S NA		taurant e, Maiden Sumeme)		
MARYLA retained by the 5 should be deti	BE (Frank Chris	stley				Violet	Mae Star	ley	
ay be retained the page 5 should the notified	5	190. INFORMANT'S NAME (Type/Print) Carol Sue Wright 200. METHOD OF DISPOSITION	Т	4 Plea	sant Vi	ew Churc	h Rd.	Port Depos	sit, N	
TOR e 6 may rector, p		1 Buriel 2 St Cremation 3 Remo	oval from State 206.1	PLACE AND DATE O Itery, crematory or other CO Crema	r disposition (Na her place) atory, In	c. 05/05	DATE 5/95	Baltimon		
BALTIMORE, after death. Page 6 may be whe funeral director, page moval.		George E. Mac	ENSEE	-	22. NAME AF	ion Soci	ety of	Maryland ltimore,		
B hours after id in by the or removal		23. PART I. Entar the diseases, or o		tha daath. Do n	ot antar the mo	da of dying, auc	ch as cardiac	or reaplretory erres	st,	Approximate
ely fille nation,		IMMEDIATE CAUSE (Final	Acquired Imm	nune Def:		Syndrome)		İ	interval Between Onset and Death
and o bur	VTION	Sequantielly liet conditions, if any, leading to immediate	Hepatic Fail	ure						
P.O. B th certificat ending phy I Hygiene p or other	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated evants resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	:					
RDS, at the dea by the att and Menta y Injury.	AL C	PART II. Other significant condition	s contributing to death but	t not resulting in	the underlying	cause given in	Part i. 24a	. WAS AN AUTOPSY	24b, WER	E AUTOPSY FINDINGS
COR irres that signed by Health an	MEDICA							PERFORMED? YES 2 NO	COM OF D	LABLE PRIOR TO PLETION OF CAUSE DEATH? YES 2 X NO
> 0 + -	AN:	DID TOBACCO USE CONTR				UNCERTAI	N 🗆			
户 F 有希腊	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1-1 Inpatient 2 ER/Outpat		OTHER:	s 5 🗆 Residence	a 🗆 au			
G THEICAN: or his certifical with the St numbed, or it	ву Рну	27. MANNER OF DEATH **XX** Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ			BE HOW INJURY OCCU	RED	
	ETED	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY - building, etc. (Specify	y)			City or To			Number,
OSPITAL. UNERAL II Ithin 72 No.	COMPL	2 MEDICAL EXAMINE	CIAN: To the best of my knowled R: On the beste of examination	dge, death occurred	set the time, date , in my opigion, d	and place, end due	to the cause(e)	end manner ee stated place, end due to the	ceuse(e) end	menner as stated.
TO THE HOSPITAL. TO THE FUNERAL De filed within 72 IMPORTANT: If	TO BE	296. SIGNATURE AND THE OF CERTIFIER	JUX	N		MD D416		29d. DATE &	GIGNED (Mon	th, Day, Year)
44		30. NAME AND ADDRESS OF PERSON WHO EUGENE CRAIG MD 31. DATE FILED (MORITA, DBY, YEAR)	VAMC PERRY P	POINT, MI	21902			<u></u>		
		MAY 0 8 1995 &	,32. REGISTRATE	A-M						DHMH-16 Rev 1/8



1 CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Migdle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Mai 2:10 4. SOCIAL SECURITY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 4 13 IF UNDER 1 YEAR IF UNDER 24 HRS. L MIN. 90 Pages 1, 2, 3 should 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNT DIRECTOR mor 10b. COUN 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 XES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 0 been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit at. of Health and Mental Hygiene prior to burial, cremation, or removal. Jehal hours after death. Page 6 may be retained by the hospital or attending physician. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ma be notified at once. 17. FATHER'S NAME (First, Middle, Last MOTHER'S NAME (First, Middle, Melden Surname) BE 194. INFORMANT'S NAME (Type/Print) 2 20a METHOD OF DISPOSITION
1 Burlel 2 Cremetion 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE - City or Town 20c LOCATION 3 🗆 R 4 Donation 5 Other (Specify) houd 0 examiner Vin arro traumatic event, the medicai 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, **Approximate** shock, or heert fallure. List only one cause Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DSIS (with bactevem) a oue to (or as a consequence of): pivation PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DOE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, or PART II. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN ME PRISICIAN: The law item 23 pas 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) this certificate h with the State [OTHER: 1 TES 2 NO patient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 26a. DATE OF INJURY TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural Pending death ВУ vestigation 2 Accident 281. LOCATION (Street and Number or Rugal Route Number City or Town, State) Suicide At home, farm, street, factory, office 3 92 COMPLETED 6 Could not be DIRECTOR: after 4 Homicide 28 THE HOSPITAL OR AT hours a 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and pieca, and due to the cause(a) end menner ea atsted. TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If IN (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ea stated. IGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SINAI HOSDITAL 32 REGISTRAR'S 60



BALTIMORE, MARYLAND 21215-0020

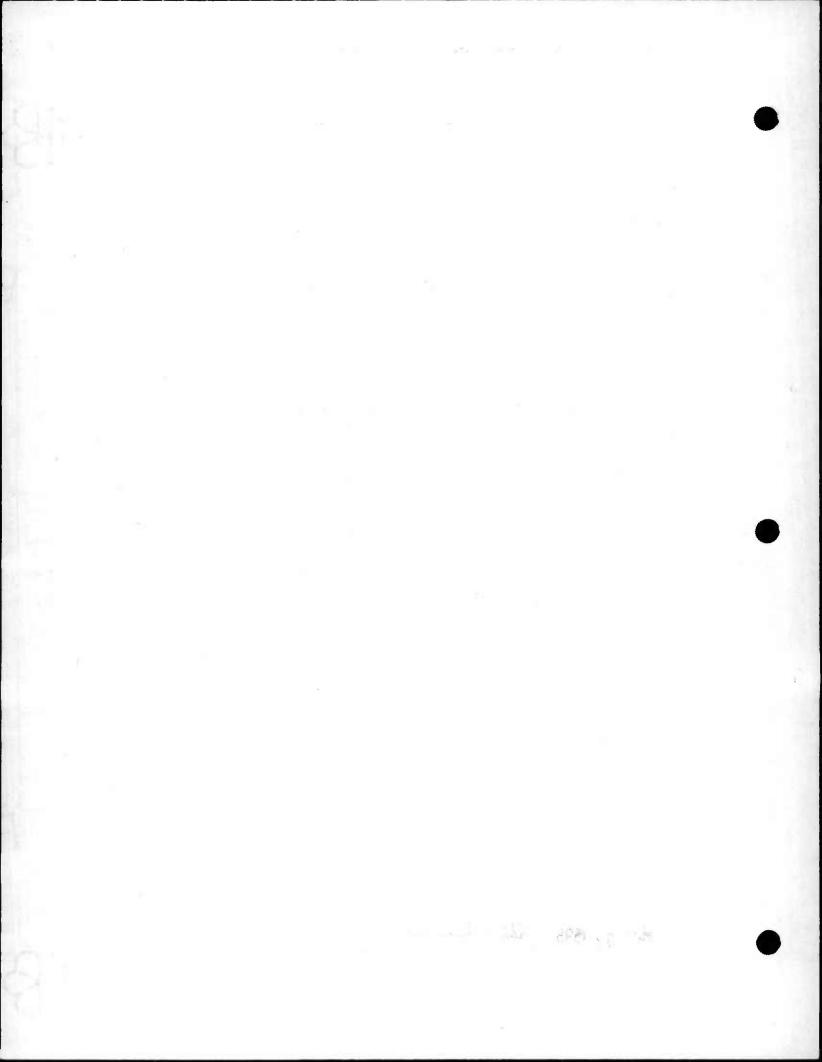
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely find in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Deni of Health and Mental Houldane prior to hours of the companion or comment.

rtem	#	1	11111	Ħ	b	123	5-8-95	N.A.	Per	Funeral	Home	

	1 - STATE REGISTRAR	STATE OF MARY		TIFICAT			MENTAL	REG. NO	_				
1	1. DECEDENT'S NAME (First, Middle, Last) REBECCA	CHAMBER	LIN	Chamb	erlain		2. DATE O	D	AY 0 /	YEAR 3	TIME OF DEATH		
			(In yrs. last birti	hday) IF UNDI	ER 1 YEAR	IF UNDER 24 HRS	-	- 4	-		ACE (State or Foreign		
8	247-05-5807	M2 F	01	RS. MONTHS		HOURS MIN.	/ (Month,	Day, Year) 25, 1		Country)	D. C :		
	9a. FACILITY NAME (If not institution, give, street	et and number)	0 4	9b, CIT	Y_TOWN OF	LOCATION OF		20,1		TY OF DEA			
08	Harbur Hospital Balto Balto												
ដ្ឋា	10a. STATE 10b. COUNTY.		100	c. CITY, TOWN	OR LOCATI	DM .							
DIRECTOR		alto	10	1	3a1	to					Od. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	100. STREET AND NUMBER 209 Bridgeview Rd 21225 109. CITIZEN OF WHAT												
BY FUN													
LED	15. DECEDENT'S EDUCAT (Specify only highest grade col		16a. DECEDE	ENT'S USUAL (OCCUPATION	of working	16b.	KIND OF BU	SINESS/IND				
COMPLET	(Specify only highest grade completed) Elementery(Seppndery (0-12) College (1-4 or 5+) N A (Give kind of work done during most of working life. Do NOT use retired.)												
	17. FATHER'S NAME (First, Middle, Last) .	ler				18. WOTHER'S	NAME (First, MI		Sumame).	ler			
B	19a. INFORMANT'S NAME (Type/Print)		19b, MA	AILING ADDRES	SS (Street an	d Number or Rur	al Route Numbe	r City or Tow	n State Zin	Code)	4		
욘	Linda Mod	ore	20	538		rnes		lace	Ba	Ifo,	md 21244		
	20a METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	at from State 20	LACE AND T	ry or other place	SITION (Nan	1 110+	- 5/5/g	2001.0	CATION C	City or Town	State		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	(00)11			ADDRESS OF	FACILITY, /	100	01193	111	113,114		
	Dealer u	Jane		1	Han		t- w		10. 0	المالية	1 21215		
	23. PART I. Enter the diseases, Dr con	npilcationa that cause	ed the death.	Do not enta						est.	Approximate		
	IMMEDIATE CAUSE (Finel	st only one cause on	esch iina.			, , ,					interval Between		
	disease or condition resulting in death) a. ANOXIC ENCEPHALOPATHY. DUE TO (OR AS A CONSEQUENCE OF):												
_					c -								
õ	Sequentially list conditions, If any, leading to immediata LARDIAC BRREST DUE TO (OR AS A CONSEQUENCE OF):												
¥	cause. Enter UNDERLYING	Muc	CARDIA	H T	NEAR	CTION					10 day		
표	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS			777	C/ 10.V					10 day		
CERTIFICATION	resulting in death) LAST	ARTER	105CLE	ROTIC	cone	NOVASC	NLAR	PISET	se.		15 year		
	PART II. Other significent conditions of	contributing to daeth	but not reaul	ting in the u	ndariying	csuse given i	in Part I.	24a, WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDING		
DICAL	RENAL FAI							PERFOR		A	MILABLE PRIOR TO OMPLETION OF CAUSE		
MED	INSULIN	05051000	A. 00.					1 TYES 2	NO		F DEATH?		
	DID TOBACCO USE CONTRIB						- IN ES			1	YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	BOTE TO CAUSE (DEATH /Check		UNCERIA	IIN M						
Ö	EXAMINER?	IOSPITAL:		OTHE	R:								
₹	27. MANNER OF DEATH	Inpatient 2 ER/Ov				5 Residenc							
ву Рну	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	260	b. TIME OF INJURY M	28c. INJU WOR 1 - YE	RY AT C? S 2 NO	28d. DEŞC	RIBE HOW I	NJURY OCC	URED			
8	3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, atc. (Spi	Y — At home, fo	arm, street, fee	tory, office			TON (Street a Town, State)	and Number o	or Rural Rou	te Number,		
	29a. CERTIFIER	Total Survivor	With Sucre Se		-	-				-			
COMPL	(Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: (Check only one)										nd manner as stated.		
Ŭ U	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE N					onth, Day, Year)		
00	Sudhe Pai					1524		- 74					
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF D	EATH (ITEM 27)	(Type, Print)		-		30 ,	/-		30 1995		
	SUPHA PAI, 7850-	TI. AMER	CANA		E , C	ien B	URNIE	- ^	0 -2	1060			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE			-							
	MAY no. 1995	This other des	Mardall										



9c. COUNTY OF DEATH Anne Arundel

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

Odenton, Maryland 21113 20c. LOCATION - City or Town, State

Baltimore, Maryland

3. TIME OF DEATN 9.45 A

8. SIRTHPLACE (State or Foreign MD

> 10d. INSIDE CITY 1 TES 2 1 NO

14. RACE — American Indian, Black, White, etc.

White

Approximete intervei Between **Onset and Death** 2 WKS

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		1. DECEDENT'S NAME (First, Midd	le, Last)									2. DATE O	F DEATH			47
				Thelma	L.	C	Carper	nter				Mav	O.	AY /1 1	995	
		4. SOCIAL SECURITY NUMBER		5. SEX	_		ast birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE O	F BIRTH	- 1	8. SIRTHP	-
		218-01-07	65	1 🗌 M 2 🗹 F		70	YRS.	MONTHS	DAYS	HOURS	MIN.		25 -	15	Country)	
2, 3 should		9a. FACILITY NAME (If not institution	n, give s	street end number)		-		9b. CITY	, TOWN	OR LOCATI	ION OF DE		20	9c. COU	NTY OF DEA	A
<i>∞</i>	۳ ا	211 W. Hil	1to	Road				Baltimore Anne Ar								
1, 2	5	RESIDENCE OF DECEDE	NT					1001	- OZII	OIC				MIL	e ALC	4
sabe	DIRECTOR	City Care	COUNT					Y, TOWN							1	1
it.		Maryland	Anr	ne Arunde	21		Ba	ltin	ore						1	1
15-0020 ending physician. as the burial-transit permit. Pages 1,	ERAL	10e. STREET AND NUMBER							10	H. ZIP COD	E			10g. CIT	ZEN OF WH	1
in. ansit	岁	211 W. Hill	top							212	225			υ	J.S.A.	
20 ysicia rial-tr	FUN	11. MARITAL STATUS 1 Never Married 2 Merri		12. WAS DECEDER FORCES?	T EVER	N U.S. A						IC ORIGIN?	(Specify Yes	or No-	14. RACE - Black,	1
000 de ph	ВУ	3 Widowed 4 Divorced	PG	IF YES, GIVE						S 2 10 NO			carr, erc.)	- 1	Specify:	
AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran	60	15. OECEDEN	rie enti	CATION		I 40. D							Tella III a sa a la sa			
121 or att	ETE	(Specify only high	est grade	completed)		(Give kind of u	work done			ng	186. F	(IND OF BU	INESS/IND	DUSTRY	
D 27	2	Elementary/Secondary (0-12) 8th		College (1-4 or 5	+)		Iome M						Dr. TI			
ANI he hos detach	COMPL	17. FATHER'S NAME (First, Middle,	nett			1	Olic 1	MACE I		40 4407			Own Ho			
YLAND by the hospit be detached at once.		The state of the s		scar Wil	liam	a Wi	nebre	nner		18. MOT			ayba1:			
NR pould	B	19e. INFORMANT'S NAME (Type/Pr					9b. MAILING			and Mumbin			_			-
MARYLAND retained by the hospit 5 should be detached notified at once.	5	Harry Carper	,	•			1094 (
		20e. METNOD OF DISPOSITION			201	_	EANDDATE				Noat		_		rylar	
OR 6 ma ector, p		1 X Buriel 2 Cremation 3 4 Donation 5 Other (Speci		oval from State	сед	netery, ci	rematory or o	ther place)	mote	arne or		DATE			Cify or Town	
		21. SIGNATURE OF FUNERAL SER		CENSIL	1	eua	T 11TT			ND ADDRE	SS OF FAC	5/8] Bal	tlmo	re, M	1
ALTIN death. Pag tuneral di i.		· nD	11	()~	4		~	Ge	org	e J.	Gond	e Fu	neral	Home	P.A.	•
- 9 -		(le	na	MXX	ton		_	40	001	Ritcl	hie I	lwy.	Balt.	imore	, Md.	
E 3 2 at		23. PART I. Enter the dieees shock, or heart t	es, or o	complications the	at cause	d tha d	laath. Do r	not antar	the m	ode of dy	ing, suct	as cardis	c or respi	ratory em	est,	
	1	IMMEDIATE CAUSE (Final		()	000 011 0											
1 ag 6		disesse or condition resulting in desth)		. Moeu	WO	01	a									
8760 Inter within completely rial, crematic				DUE TO	(OR AS A	CONS	EOUENCE OF	F):								
C 68760 executed with and complet to burial, crem	2	Sequentielly list conditione,		b												
	CERTIFICATION	if sny, lesding to immediate csuse. Enter UNDERLYING		DUE TO	OR AS	CONSE	EOUENCE OI	F):								
BOX ficate be physician ne prior te	5	CAUSE (Disesse or Injury	< □	c.	40D 40 4											_
Certifi dling p	E	thet initisted events resulting in deeth) LAST	1	502 10	(OR AS A	CONSE	EOUENCE O	-):								
اه چيو ا	ij II	545 84 - 53517 1 12		d												-
이 의 원호 클		PART II. Other significant co	ndition	s contributing to	deeth b	ut not	regulting i	in the un	deriyin	g cause	given in !	Pert I. 2	4a. WAS AN		24b, W	٧
ORC that the led by th and any in	EDICAL	Congestiv	0	Heaset	dai	ille	He,	Ca	*C	ino	Ma		PERFOR		C	A
ECOR equires that in signed by if Health an	ME	OF Bre	an	H	A							_ '	1 163 2	DIAC	0	H
St. of See 18	11	DID TOBACCO USE C	ONT	RIBUTE TO CA	USF O	E DE	ATH YE	SDI	VO F] IINC	ERTAIN				'	
See a	₹ I	25. WAS CASE REFERRED TO MED					CE OF DEAT				LIVIAII					-
SICIAN: The certificate h the State h	Sic	EXAMINER?		HOSPITAL:	VER/Out	antient	3 🗆 DOA	OTHER			atd	B 🗆 Other (0			-
正品等	PHYSICIAN:	27. MANNER OF DEATN		28e. DATE OF	INJURY		28b, TIM	E OF	28c. IN-	JURY AT	Islounce		RISE HOW II	NJURY OC	CURED	-
NG PHYS ath with		1 Netural 5 Pendle		(Month, E	Day, Year)		INJ	URY	W	ORK? YES 2	NO NO					
ON NOING I: After r death is ma	BY	2 Accident Investi 3 Suicide 8 Could		28a. PLACE C	OF INJURY	— At h	ome, ferm, a	rtreet, fect				28f, LOCAT	ION (Street a	nd Number	or Rural Rou	
DIVISION OR ATTENDING F DIRECTOR: After hours after death item 28 is mar		4 Homicide determ		building,	atc. (Spec	cify)							Town, State)			
DIV OR A DIREC hours	9	29a. CERTIFIER	DUVE	CIAN. To the best of								_				
= 24 F	COMPLET			CIAN: To the best of a												
HOSPITAL FUNERAL WITHIN 72	8					10/01	valige#0	, iii my 0	pittiOff, (nu piaca, en			
THE HOSPI TO THE FUNE Filed within	H	296. SIGNATURE AND TITLE OF C			MD					-	ENSE NUM			29d. DAT	E SIGNED (A	A
2 2 3 2	0	1410 X 111	'MI	1501	IND	,				104	510	25			May 4	i

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE

707 E. Fort Avenue

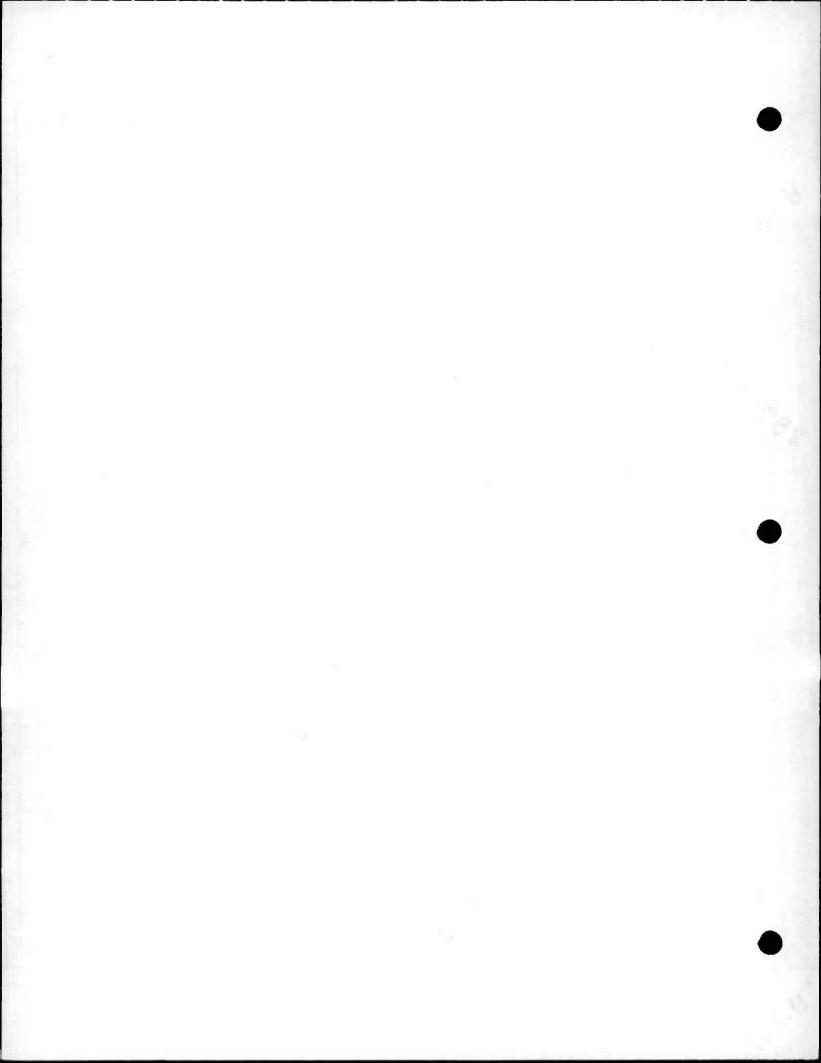
Dr. Afroze Muneer

MAY 0 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

24a. WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 100 OF DEATH? 1 | YES 2 NO ESCRIBE HOW INJURY OCCURED OCATION (Street end Number or Rural Route Number, ty or Town, State) ause(e) end menner ae stated. its end place, end due to the ceuse(e) and menner se stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 045105 May 4, 1995 Baltimore, Maryland 21230 DHMH-18 Rev 1/89



		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
		1. OECEDENT'S NAME (First, Middle, Leat) Joseph Christen Christiansen 2. DATE OF DEATH MONTH DAY YEAR 5:50	
pin		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 472 - 50 - 9080 1 \(\) M 2 \(\) F 48 YRS. 6. AGE (In yrs. last birthday) 48 YRS. 6. AGE (In yrs. last birthday) 48 YRS. 6. AGE (In yrs. last birthday) 48 YRS. 7. DATE OF BIRTN (Month, Day, Year) JUNE 16, 1946 MINN. 98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATN 99. CITY, TOWN OR LOCATION OF DEATN 99. COUNTY OF SEATH	ign
1, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH N/A PESIDENCE OF DECEDENT	
nit. Pages	DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Dundalk 1 □ YES 2XX No.	0
physician. burtal-transit permit. Pages	FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 108. CITIZEN OF WHAT COUNTRY? 108. STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY? 110. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ADMED.	
	В	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Never Married 2 X Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. Wildowed 4 Divorced 14. RACE — American Indian, Black, White, atc. Specify: 15. Was DECENDENT OF NISPANIC ORIGIN? (Specify Year or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 16. RACE — American Indian, Black, White, atc. Specify: White	•
hospital or attending tached for use as the	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lieutenant Police Department	
by the	ш	17. FATHER'S NAME (First, Middle, Lest) Atvid Christiansen 18. MOTHER'S NAME (First, Middle, Malden Surname) Millie Gillie	
ay be retained bage 5 should be notified	TO B	198. INFORMANT'S NAME (TyperPrint) 19b. MAILING ADDRESS (Street and Number or Purel Pourle Number, City or Town, State, Zip Code) 106 Kinship Road Dundalk, Maryland 21222	
me 6 m		20e. METHOD OF DISPOSITION 1 (% Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametagy, crymptory of other place) Bel Aur Mem. Gdvs. 5/6/95 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACH TX	
9 - 9		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222	
within 24 hours opletely filled in cremation, or n		23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate interval Bett Onset and Education of the consequence of: Due to (or as a consequence of):	ween
th certificate be execute ending physician and co I Hygiene prior to bunia or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): ACUTE HEMORRHAGIC PANCREATITIS DUE TO (OR AS A CONSEQUENCE OF): d.	
w requires that the deal to been signed by the ath pt. of Health and Menta shows any injury,	MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE 24a. WAS AN AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU OF FEATURE 1 YES 2 NO	JSE
The la	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:	
PHYSICIAL this certif with the	BY PHYSI	1 YES 2 NO HOSPITAL: OTHER: A Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO Natural 5 Pending Natural 6 Natural 7 Natural 8 Natural 8 Natural 8 Natural 9 Natu	
OR ATTENDING DIRECTOR: After hours after death fern 28 is ma		3 Suicide 6 Could not be determined 5 Could not be determined 286. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 286. PLACE OF INJURY — At home, term, street, factory, office City or Town, State)	
E 25 E	COMPLETED	29e. CERTIFIER (Check only One) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.	ed.
TO THE HOSPI TO THE FUNER be filed within	TO BE (296. SIGNATURE AND TITLE OF CERTIFIER MAY 2, 1991) 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (MONTH, Day, Year) MAY 2, 1991	5
71		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHURCH WOJE 100 N. Broadway BAIL MORE Md. 21231	
		31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE July 0.8 1995 July d'Autobart Robell	

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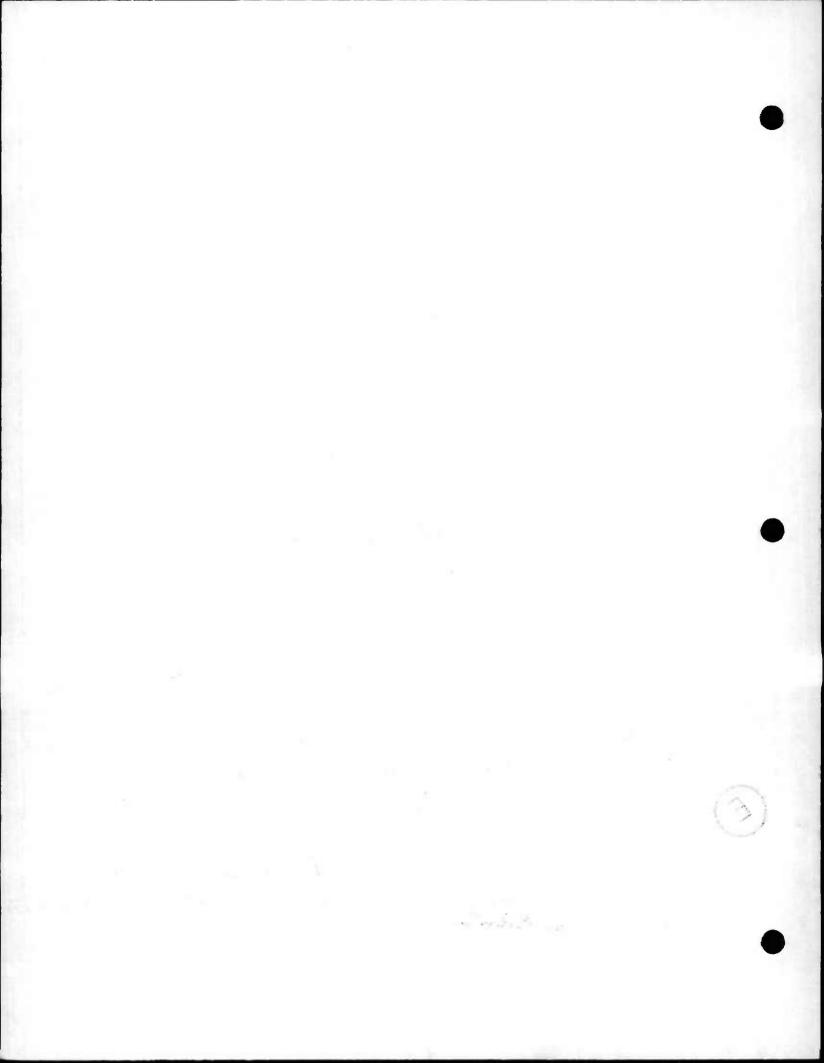
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DIVISION OF VITAL RECORDS, P.O. BC	The state of the s
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		1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H		REG. NO.		
	1	1. DECEDENT'S NAME (First, Middle, Lest) LESTER DOBIE				2. C	DATE OF DEATH	5 9	3. TIME OF DEATH 10:48P M
29		4. SOCIAL SECURITY NUMBER 218-74-8051	X□ M 2 □ F	E (In yrs. last birthday) 34 YRS.	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. 7. D HOURS MHN.	Moreh, Day Year)	61 M	BIRTHPLACE (Stete or Foreign Country) ARYLAND
2, 3 should	стоя	90. FACILITY NAME (If not institution, give st 13 S. PAYSON S	REET		BALTI	ORE		9c. COUNTY N/A	OF DEATH
Pages 1,	DIRECT	100. STATE 100. COUNTY MARYLAND N/A			Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1* YES 2 \(\text{NO} \) NO
n. ansit permit.	FUNERAL	13 S. PAYSON S	STREET			21223		U.S	OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	ВҰ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	13. WAS DEC If yes, sp. 1 YES	ENDENT OF HISPANIC OF BELLEVILLE OF HISPANIC OF BELLEVILLE	RIGIN? (Specify Yes erto Rican, atc.)	or No.— 14.	RACE — American Indian, Black, White, etc. Specify: BLACK
5 6 2	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		160. DECEDENT'S (Give kind of the life. Do NOT us DISAB		DN st of working	16b. KIND OF BUS	SINESS/INDUS	
I Y LAND I by the hospital of be detached to at once.	BE COMP	17. FATHER'S NAME (First, Middle, Last) GOLDIE DOBIE				18. MOTHER'S NAME (F. LAURA T.		Surneme)	
be retained to ge 5 should e notified	TO B	GRETA SCOTT		19b. MAILING 622 L	OWGROUP	ND RD.EMP	ORIA, V	n, State, Zip Co IRGIN	IA 23847
GE 6 may be irector, page		2045 METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State c	Ob. PLACE AND DATE (ametery, crematory or o	of disposition (Nether place) MT.	ZION 5	OATE 20c. LO BALT	CATION — CITY FIMORI	or Town, State E, MARYLAND
BALIIMOKE hours after death. Page 6 may ed in by the funeral director, pa or removal. medical examiner must b		21. SIGNATURE OF FUNERAL SERVICE MC	me		10000	T CARROLL		AL HOI	AVENUE ME1712W.NORT
within at pletety fill cremation.		23. PÄRT I. Enter the diseases, or cahock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	lat only one cause on	each lina.	Fail		cerdiec or respi	ratory arrest	Approximate interval Between Onset and Death
certificate be execute sing physician and co lygiene prior to buria	CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		A CONSEQUENCE OF					
ires that the signed by the lealth and M	EDICAL	PART II. Other significent conditions	contributing to death	but not resulting	in tha underlying	g cause given in Part	1. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law as been 23	AN: M	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YE		UNCERTAIN []		1 - YES 2 - 7%Q
ate ate	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	ripstient 3 DOA	OTHER: 4 - Nursing Home	5 Spiesidence 6 🗆 6	Other (Specify)		
The certificate this certificate with the St marked, or It	ву Рн	27. MANNER OF DEATH Natural 5 Pending Accident Investigation	28s. DATE OF INJURY (Month, Day, Year,	NIA	WOI 1 Y	RK? / ES 2 NO	N/A		
	ETED	13 Suicide 8 Could not be 4 Homicide determined	26e. PEACE OF INJUI building, etc. (Sp	RY — At home, farm, a	treet, factory, office		LOCATION (Street e City or Town, State)	M Number or F	Burel Route Number,
SP AND AND AND AND AND AND AND AND AND AND	COMPL		IAN: To the bast of my kno					d due to the ce	puse(s) and menner se stated.
TO THE HOSE TO THE FUNE Be filed with	O BE C	290. SOMATURE AND STLE OF SERTEMEN	5			29c. LICENSE NUMBER D2/42	0	29d. DATE SI	GNED (Month, Dey, Year)
-	F	10. MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	DEATH (ITEM 27) (Type,	Print)	2.)	0	,	

DF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

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		FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
		1. DECEDENT'S NAME (First, Middle, Last) CHARLES AUG	GUSTUS De	Gallesc	CA IR		DATE OF OEATH	9, 199	3. TIME OF DEATH			
2		4. SOCIAL SECURITY NUMBER 220-24-8939	5. SEX 6. AGE (I	In yrs. last birthday)	IF UNDER I YEAR MONTHS DAYS	IF UNDER 24 HRS. 7	Month, Day, Year)	8. B	S 9 1 06 f) IRTHPLACE (State or Foreign ountry) Md.			
1, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give to 8213 OLD Ha	rford Rd,		PARK	R LOCATION OF DEAT		Balt				
Pages	DIRECTOR	Md 106 COUNT	Itimore		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
KYLAND 21215-0020 of by the hospital or attending physician, uid be detached for use as the burial-transit permit, ed at once.	FUNERAL	0410	Harford Rd			21234	-\	U:	OF WHAT COUNTRY?			
	ВУ	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR OA	2 NO	If yes, sp	ENDENT OF HISPANIC ecity Cuben, Mexicen, I 2 M NO Specify:	ORIGIN? (Specify Yes Puerto Rican, atc.)	5	RACE — American Indian, Black, White, etc. Specify:			
	PLETED	15. DECEOENT'S EOU (Specify only highest grade Elementery/Secondery (0-12)	CaTION completed) College (1-4 or 5+)	16a, DECEDENT'S US (Give kind of wo life, Do NOT use	rk done during mo retired.)	st of working	18b. KINO OF BU	SINESS/INDUSTF				
	E COMP	17. FATHER'S NAME (First, Middle, Last)	Galleford	-	0-0	18. MOTHER'S NAME	(First, Middle, Malden		,			
be retain ge 5 sho e notifi	TO B	19e. INFORMANT'S NAME (Type/Print)	alleford		OLD F	nd Number or Rural Rou	te Number, City or Tow	n, Stete, Zip Code	. 21234			
nORE le 6 may rector, pa		20e METHOO OF DISPOSITION 1 M Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	noval from State come	PLACE AND DATE OF etery, crematory or other Ulaney Vol	ley Mer	n. Gans	5/2 AS TIT	MODIUM				
ALII death. P funeral	The 2015	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	R		O ADDRESS OF FACIL S CHAPEL O HOUSOID	of Men	nories elto.M	d.21234			
ted within 24 hours after to completely filled in by the fall, cremation, or removal.		IMMEDIATE CAUSE (Final	complications that caused List only one cause on ea a. A cute M DUE TO (OR AS A	ich lina.	lial 12	forctio	No.		Approximate Interval Between Onset and Deeti			
th certificate be executed by the certificate be executed by the certificate and it hygiene prior to burnor or other traumatic	CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	Acute	mycca	relaci i	fir e T	tin 1576			
at the by the will be	AL	PART II. Other eignificant condition	ns contributing to death bu	at not resulting in	tha undarlying	ceuse given in Pa	rt i. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
TAL RECOR	SICIAN: ME	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF DEATH	(Check only one)	UNCERTAIN			1 YES 2 NO			
PHYSICIAN: this certifica with the St with the St	BY PHYSI	1 VES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending	HOSPITAL: 1 Inpatient 2 ER/Outpa 28e. DATE OF INJURY (Month, Day, Year)		OF 28c. INJU	JRY AT 28	Other (Specify)	NJURY OCCURE	D			
ATTENDING I	TED	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF NJURY building, etc. (Specif	— At home, farm, stre	eet, fectory, affice	28	M. LOCATION (Street of City or Town, State)	and Number or Ru	ral Route Number,			
	COMPLE		CIAN: To the best of my knowle						se(s) and menner se stated.			
THE H THE H IMPORT	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIED	moggid	Zuk		DO 69		29d, DATE SIGN	NED (Month, Day, Your)			
0		30. NAME AND ADDRESS OF PERSON WH 8 (See / Lange 31. DATE FILEO (Month, Dey, Year)		Sulle	, M	D 2123	34 DR.G	ierald N	Neggid			
		MANY A R 100F d	11 4 . 0									

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		FOR	STATE OF R	MARYI A	ND / DEPAR	TMEN	T OF H	IFAITH	AND	MENT	TAL HYCIEN	J U	, ,	
_	_	1 - STATE REGISTRAR			CERTIF	ICAT	E OF	DEA	TH	MI CIT I	REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)		DIGIORGIO 2. DA MAY					2. DATE OF DEATH MONTH YEAR MAY 4,1995		3. TIME OF DEATH			
		Nicolo 4. SOCIAL SECURITY NUMBER	5. SEX		Vrs. lest birthdev)					+ -				
		4.5	S. SEA ÚXÍ M 2 □ F	6. AGE (III	yrs. lest birthday) YRS.	MONTHS	DAYS	HOURS	MIN.	_(Mc	TE OF BIRTH onth, Day, Year)		8. BIRTHE Country	PLACE (State or Foreign
		9a. FACILITY NAME (If not institution, give st		67	rna.						PT. 15 1	929	LIF	177
	E I	- Id. C	ARE HOCK	27.0		98. 01	Y, TOWN C	O O	ION OF D	EATH	,		NTY OF DE	
Hi	5	RESIDENCE OF DECEDENT		TIR	-		Wisi	UAN			Baltimor			e
	뿔	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
FRANKIN SQUARE HOSPITAL ROSSOALE BALT RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION PARYLAND BALTIMORE REKYLLE								1 YES 2 NO						
	FUNERAL	10e. STREET AND NUMBER	201. P				101	. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
		11. MARITAL STATUS		040				9	331	+			U	- A-2
		1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	YES	2.X NO		If yes, spe	ecify Cubi	nn, Maxica		GIN? (Specify Yes to Rican, etc.)	or No—	14. RACE Black,	— American Indian, White, atc.
l	'n	3 Widowed 4 Divorced	IF YES, GIVE W	WAR OR DAT	ES		1 TYES	Z NO	Specif	y:			Spec/ly	ICTE .
18	3	15. DECEDENT'S EDUC	CATION		16a. DECEDENT'S	USUAL C	CCUPATIO	ON		1	16b. KIND OF BU	SINESS/IND	DUSTRY	2/11/2
1	COMPLEIED	(Specify only highest grade Elamentary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of a life, Do NOT us	work done	during mo	st of world	ng		BALTIM	10 Re.	neal	ty Board
. 3	Ĭ	SYRS			Custo	DIA	N			- 1	UQ2 70	CATT	20	
at once	5	17. FATHER'S NAME (First, Middle, Last)	0					18. MOT	HER'S NA	ME (Firs	st, Middle, Maiden			
ر ا ق	u	SALVATORE L	Ji bioR	0,0				A	201	LA	(sRn	i (shi	A	
	2	19a. INFORMANT'S NAME (Type/Print)			19b, MAILING	ADDRES	S (Street a	nd Numbe	r or Rural	Route No	umber, City or Tow	n, State, Zij	Code)	1 21234
		SALVATORE DiG	rioRbic)	1098	Ava	2000	$zl\rho$	KOP	0	HARK	: علا:	MAR	YLAND
20s. METHOO OF DISPOSITION (MS Burlal 2 Coremetion 3 Ramoval from State 20b. PLACEAND DATE OF DISPOSITION (Name of pametery, prematory or other place) 20c. LOCATION — City or pametery, prematory or other place)							City or Tow	n, State						
Seminal 2 Gremation 3 Ramoval from State Camatery, crematory or other place) Seminal Camatery Ca								ARYLAM						
exa		Vonde of Cro	100			2	2000	AHC		30	50m +	Park	15110	
medical	٦	23. PART I. Enter the diseases, pr c	omplications the	t causad t	tha death. Do r	not entar	the mp			h as c	ardiac or respi	ratory an	reat.	Approximate
	1	shock, or heart failure. I	List only one cau	se on eac	th line.									Interval Batween Onset and Death
2		disease or condition	Anaerob	vic s	eneie									2days
event,	ì	reaulting in death)	DUE TO	(OR AS A C	ONSEQUENCE OF									
	2		Metasta	itic p	prostat:	ic c	ance	r						6months
y, or other traumatic	2	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A C	ONSEQUENCE OF	F):								
	5	cause. Enter UNDERLYING CAUSE (Disease or Injury	2											
other P		thet initieted events	DUE TO	(OR AS A C	CONSEQUENCE OF	F):								
5 0		resulting in death) LAST	J											
3 3	. 11	PART II. Other algnificant conditions	contributing to	deeth but	not regulting i	in the ur	darivino	Cause	given in	Part I	24a. WAS AN	ALITOPSV	24b 1	WERE AUTOPSY FINDINGS
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anows any in											1 TYES 2	X NO		OF DEATH?
Ous .	E	DID TOBACCO USE CONTR	DIDLITE TO CA	LICE OF	DEATH VE			1 11516	EDTA IA					I YES 2 NO
S A		25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CA		PLACE OF DEAT			UNC	ERTAIN	ч Ц				
BHYSICIAN: MEDICAL	<u> </u>	EXAMINER?	HOSPITAL:			OTHE	R:							
2 2		27. MANNER OF DEATH	28a. DATE OF		28b. TIM	- Y	28c. INJU	-	sidence		her (Specify) DESCRIBE HOW II	U II II II O O O	CHRED	
		1 Natural 5 Pending	(Month, De		INJ	URY M	WOI		ON	200. 0	ESCHIBE HOW II	NJUNT UC	LUNED	
A C		2 Accident Investigation 3 Suicide Could not be	28a. PLACE Of	F INJURY -	- At home, farm, a	treat, fact				28f. LC	DCATION (Street a	and Number	or Burni Bo	uta Mumbar
3 Suicide 4 Homicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State) 28b. LOCATION (Street and Number City or Town, State) 28c. CERTIFIER (Check only one) 29a. CERTIFVING PHYSICIAN: To the basis of my knowledge, death occurred at the time, date end place, end due to the cause(a) end manner se attact one) 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the								or righter (10	Rurel Route Number,					
	1	29a. CERTIFIER 150 CERTIFYING PHYSIC	CIAN: To the heat of	my knowled	Ina doub com	of an ar	lma a	and of						
N ON		(Check only one) 2 MEDICAL EXAMINER												and manage or state t
		296. SIGNATURE AND TITLE OF CERTIBER		1		, my (,				end place, an			
5 4	1	The or certain	11/16	6	uson	20			175			29d. DAT	E SIGNED /	Morth, Day, Year)

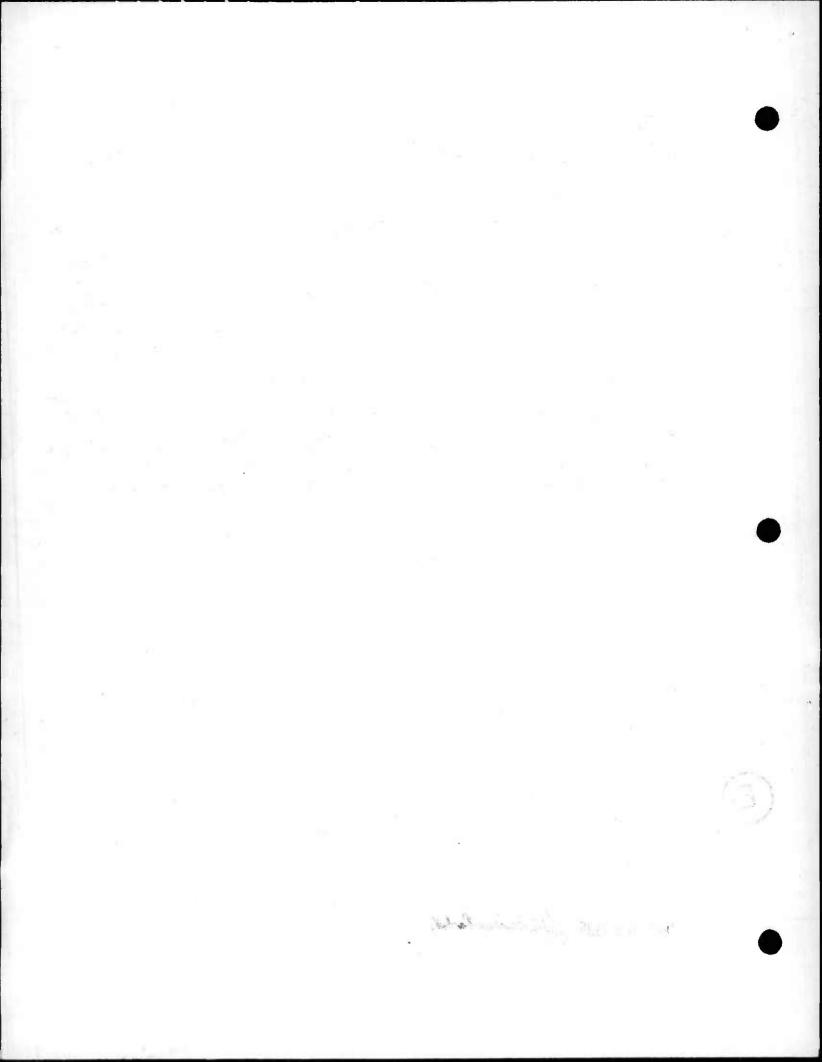
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Robert Delatorre 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. DATE FILED (Month, Day, Mar)

MAY 0 8 1995

R D 1757



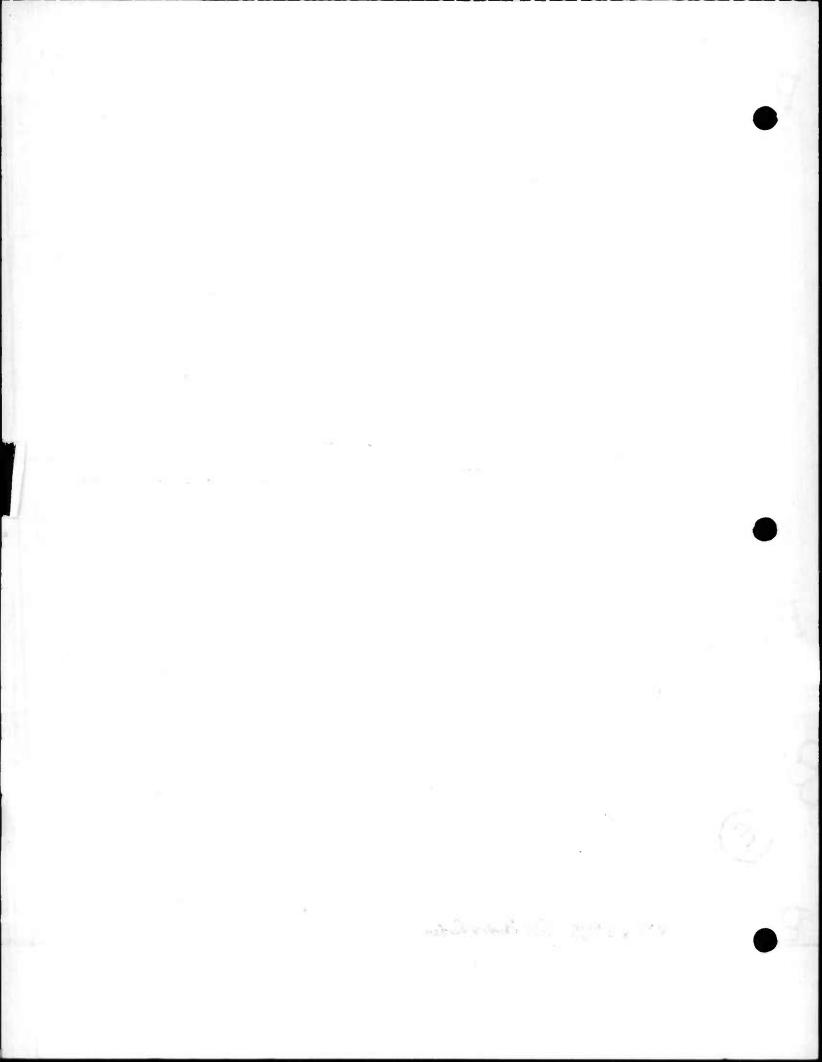
FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH HEERY LEE DYAL 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPI ACE (State or Foreign 260-28-2531 (Month, 9ay, Your) 928 1X M 2 | F 67 FLORIDA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and numi 9b. CITY, TOWN OR LOCATION OF DEATH 9c. CDUNTY OF DEATH 601 N. EUTAW STREET BALTIMORE DIRECTOR N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY MARYLAND BALTIHORE N/A 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 601 N. EUTAW STREET 21201 U.S. in and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES ☑ . Ⅵ . Ⅵ . Ⅰ Ⅰ hours after death. Page 6 may be retained by the hospital or attending physician. 11, MARITAL STATUS 13. WAS DECENDENT DF HISPANIC ORIGIN? (Specify Yaa or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.)
1 □ YES 2 ☒ NO Specify: 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 N Married BY Specify: BLACK 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Щ Elementary/Secondary (0-12) College (1-4 or 5+) PRRSSER 10 DRY CLEANING COMPL notified at once. 17. FATHER'S NAME (First, Middle, Lest)
ERNEST ROYAL 18. MOTHER'S NAME (First, Middle, Malden Surname)
DOROTHY DYAL 19a. INFORMANT'S NAME (Type/Print) DDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code)

N. EUTAW STREET BALTIMORE MARYLAND 19b. MAILING ADDRESS (Str 2 RUBY DYAL pe 20c. LDCATION — City or Town, Stata
BRUNSWICK, GEORGIA 26. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 1-13 Burial 2 Cremation 2 Ren 4 Donation 5 Other (Specify) netery, cremetory or other place) BRUNSVICK examiner 21, SIGNATURE OF PUNERAL SERVICE-LICENSEE 22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL 1712 W. NORTH AVENUE the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only ona cause on such lins interval Between IMMEDIATE CAUSE (Finsi Onest and Dasth disesse or condition resulting in dasth) Ath. Sta swalh months event, DUE TO (DR AS A CONSEDUENCE OF) traumatic CERTIFICATION Sequentially list conditions DUE TO (DR AS A CONSEQUENCE OF) if sny, lasding to immediats cause. Enter UNDERLYING attending physician CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE DF) that initiated events resulting in dasth) LAST Injury, or the after PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 YES 2 NO 1 TYES 2 TYND been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Z has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL OTHER: 1 VES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 8 Other (Specify) the 0 (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, N/A 1 Watural M 1 YES 2 X NO ВҰ Seath A ter 2 Accident 28e. PLACE OF INJURY — At home, term, atreet, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, 3 Suicide 2 8 Could not be G CTOR è N/A4 Homicide 28 datarmined N/A COMPLET 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day. BE 29c. LICENSE NUMBER 99 2 COMPLETED CAUSE OF DEATH (ITEM 27) (App. Print) 30. NAME AND ADDRESS DE PERSON WHO MUL MAY 0 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020 For hours after death. Page 6 may be retained by the hospital or attending physician. Miled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should			t. Pages 1, 2, 3 should
	BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	ed in by the funeral director, page 5 should be detached for use as the burial-transit permit

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ir death. Page 6 may be retained by the hospi	TO THE HOSPITAL OF AMERICANG PHYSICIAN: The law requires that the death certificate be executed within the found after death. Page 8 may be retained by the hospital
DATE TO THE PARTY OF THE PARTY	

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL	HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)	D. Duo	DERAR			2. DATE (OF DEATH		3. T	ME OF DEATH	ı M
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 9. Months Days Hours Min. 1. Day Sear) 1. Day Sear) 1. Day Sear)									E (State or For	elgn
CTOR	99. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH CARDEY RESIDENCE OF DECEDENT 97. COUNTY OF DEATH CARDEY										
L DIRECTOR	10e. STATE 10b. COUNT 10e. STREET AND NUMBER	J. more	10c. CITY,	CARNS	Y			10d. INSIDE CITY LIMITS? 1 TYES 2 NO			10
FUNERAL	3316 Summ	12. WAS DECEDENT EVER IN	III S ADMEN	101, ZIP CODE 10g. CITIZEN OF WHAT COUN 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No							
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? YES IF YES, GIVE WAR OR DO	2 NO	Il yee, spe	city Cuben, Mexica ZX NO Specif	en, Puerto R	(Specify Ye	s or No	Black, Whi	mericen Indier	١,
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondery (0-12)	College (1-4 or 5 +)	16e. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo:	N t of working	16b.	KIND OF BU	SINESS/INDUST	rry	1 134	
COMP	17. FATHER'S NAME (First, Middle, Lest)	-000000	MADAIR	10506	18. MOTHER'S NA	ME (First, M	iddle, Maiden	ROCIC Sumeme)			
TO BE	190. INFORMANT'S NAME (Type/Print) BERGER S	DUDSKAR DUDGEAR	196. MAILING A	ADDRESS (Street a	nd Number or Rural	Route Numb	er, City or Tou	rn, State, Zip Coo	10 01	21231	+
	20e. METHOD OF DISPOSITION Description Method		PLACE AND DATE OF		me of	DATE 5	20c, LC	CATION - CITY	or Town, S	2/10	00
	21. SIGNATURE OF FUNERAL SERVICE LI		182.7.50	22. NAME AN	D ADDRESS OF FA		Mer	briss	Kari W	AKYLA:	() .
ATION	23. PART i. Entar the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one reuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OR): Approximate interval Between Onest and Death Approximate interval Between Onest										twean
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)	:							
AL.	PERFORMED? AMAILABI COMPLE 1 YES SE NO OF DEAT									E AUTOPSY FIN LABLE PRIOR T PLETION OF CA DEATH?	O IUSE
PHYSICIAN: MEDIC	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL		CAUSE OF		S NO)				
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	525 Residence	8 🗆 Other	(Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	RY WO	RY AT RK? ES 2 NO	26d. DESC	CRIBE HOW	NJURY OCCUR	ED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined Central Home, Ierm, street, Isctory, office Determined See. PLACE OF INJURY — At home, Ierm, street, Isctory, office City or Town, State) 26e. PLACE OF INJURY — At home, Ierm, street, Isctory, office City or Town, State)									\exists	
COMPLETED		ICIAN: To the best of my knowl ER: On the basis of examination							ruse(e) end	menner as ste	ted.
TO BE CO	296. MANATURE AND TITLE OF CENTIFIC										
	DR. RICHARD	O COMPLETED CAUSE OF DE	01 A		mell	BR	1065	Rose) 7	amor	
	MAY 0 8 1995	THE STATE OF THE SERVE	70年								

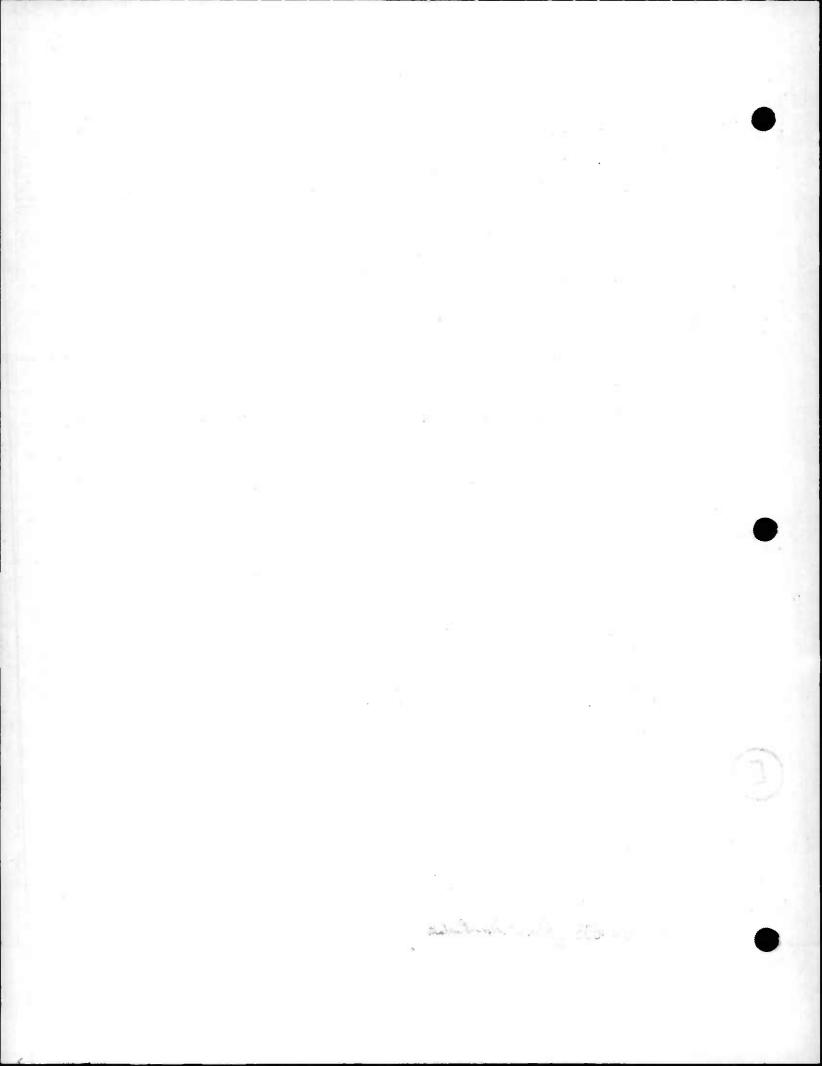
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BALTIMORE, MARYLAND 21215-0020

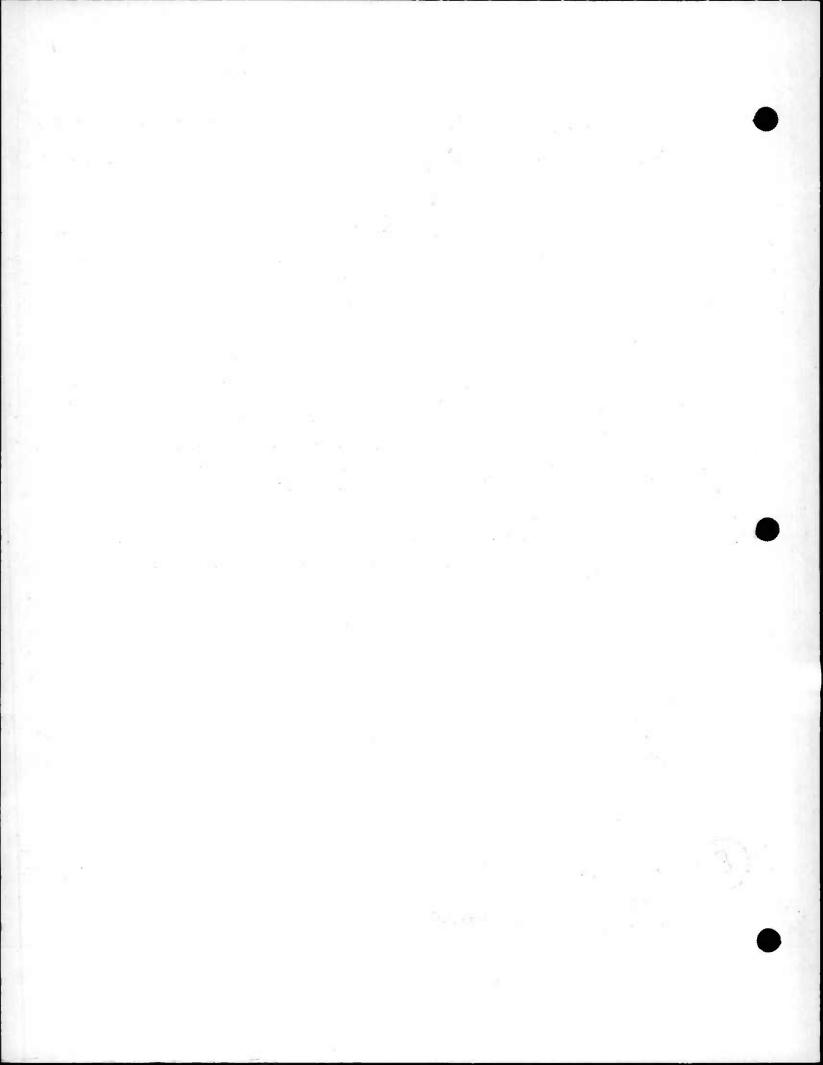
IAN: The law requires that the death certificate be executed within a wours after death. Page 6 may be retained by the hospital or attending physician.

The law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be state before the transit permit. Pages 1, 2, 3 should be stated by the burial-transit permit. Pages 1, 2, 3 should be stated by the profit of Health and Mental Hygine prior burial, cremation, or removal. DIVISION ON VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL DRAFTENDEN. The law requires that the death certifican by the FUNERAL DIRECTION And the certificate has been singed.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPA	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Las	L. Davis		2. DATE OF DEATH DAY	YEAR 3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthdey)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	S. BIRTHPLACE (State or Foreign			
	213-07-4240	1 № M 2 □ F 80 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year) NOV: 15, 1914	4 SOUTH CAROLINA			
·	9a. FACILITY NAME (If not institution, give		9b. CITY, TOWN OR LOCATION OF DE		COUNTY OF DEATH			
OT	RESIDENCE OF DECEDENT	URS HOSPITAL	BALTIMO	ORE	NIA			
DIRECTOR	10a. STATE 10b. COUN		TY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
	MARYLAND ANNE ARUNDEL SEVERN 104. STREET AND NUMBER 106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHA							
BY FUNERAL	7904 S, CAR	TIER COURT	211	44	USA			
I S	11. MARITAL STATUS / NGLE 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAN If yes, specify Cubsn, Maxica	IIC ORIGIN? (Specify Yas or N	0— 14. RACE — American Indian, Black, White, atc.			
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TYES 2 NO Specify		Specify:			
ED	15. DECEDENT'S Et (Specify only highest gra		S USUAL OCCUPATION I work done during most of working	16b. KIND OF BUSINES	SS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	use retired.)					
OMP	17. FATHER'S NAME (First, Middle, Last)	L/	HORER IS MOTHER IN	ME (First, Middle, Malden Surna	PRODUCE WAREHOUSE			
S S	GEORGE	DAVI	5 NANO		NOODARD			
TO BE COM	19a. INFORMANT'S NAME (Type/Print)		G ADDRESS (Street and Number or Rural I					
		ARRISON 19904	5, CARTIER	CT. SEVERN,				
	20s METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Re 4 Donation 5 Donate (Specify)	moval from Stata cametery, crematory or	other place)	chic and	ON — City or Town, State			
	21. SIGNATURE OF THERA. SERVICE		22. NAME AND ADDRESS OF FA	CILITY	DARD CO, MARYLAND			
CYGIII	1 h (b)	- 6	JOSEPH H. BRO	WN JR FUNERA	L HOME,P.A. LTIMORE, MD. 21223			
9	23. PART I. Enter the diseases, D	r complications that caused the deeth. Do			ry arreat, Approximete			
	IMMEDIATE CAUSE (Final	e. Liet only one ceuse on each line.	0		Intervel Batween Onset and Death			
1	disease or condition resulting in death)	· Lung	Cancer					
	_	DUE TO (OR AS A CONSEQUENCE O	on to	1 . P				
9	Sequentielly list conditions, if any, leading to immediate	DUE TO (OH) AS A CONSEQUENCE O	OFE (armere				
S	CAUSE (Disease or Injury	E. SUPPLIED AS A CONSEQUENCE OF	nsine	Cardi	o dos culou			
CERTIFICATION	that initiated eventa resulting in death) LAST	I le n sus	*1	1	Disease			
	PART ii Other significant condition	one contributing to deeth but not resulting						
	Dialet		in the underlying cause given in	PERFORMED	? AVAILABLE PRIOR TO			
MEDIC	Chronic	abstructi	ne Puly	1 VES .2	DF DEATH?			
AN: ME	DID TOBACCO USE	CONTRIBUTE TO CAUSE OF	DEATH YES NO	D J				
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (Ch	eck only one)				
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	1 Netural 5 Pending	(Month, Day, Year) IN	JURY WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJUR	Y OCCURED			
D BY	2 Accident Investigation 3 Suicide 8 Could not b	28s. PLACE OF INJURY - At home form		281. LOCATION (Street and Ni City or Town, State)	umber or Rural Route Number,			
	4 Homicide datarmined	Tantang etc. (apoonly)		City or lown, State)				
COMPLETED		SICIAN: To the best of my knowledge, death occur NER: On the best of examination and/or investigat						
BE COI	29b. SIGNATURE AND TITLE OF CERTIF	IER () (IA 7	29c. LICENSE NUM	ABER 29d	I. DATE SIGNED (Month, Day, Year)			
10 B	TLORISM	K. OM & N	1.0 030	355	4/28/95			
-	30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ	BON SI	E Cours	Hospital			
	MAY 6 8 1995	37 REGISTRAR'S GNATURE						



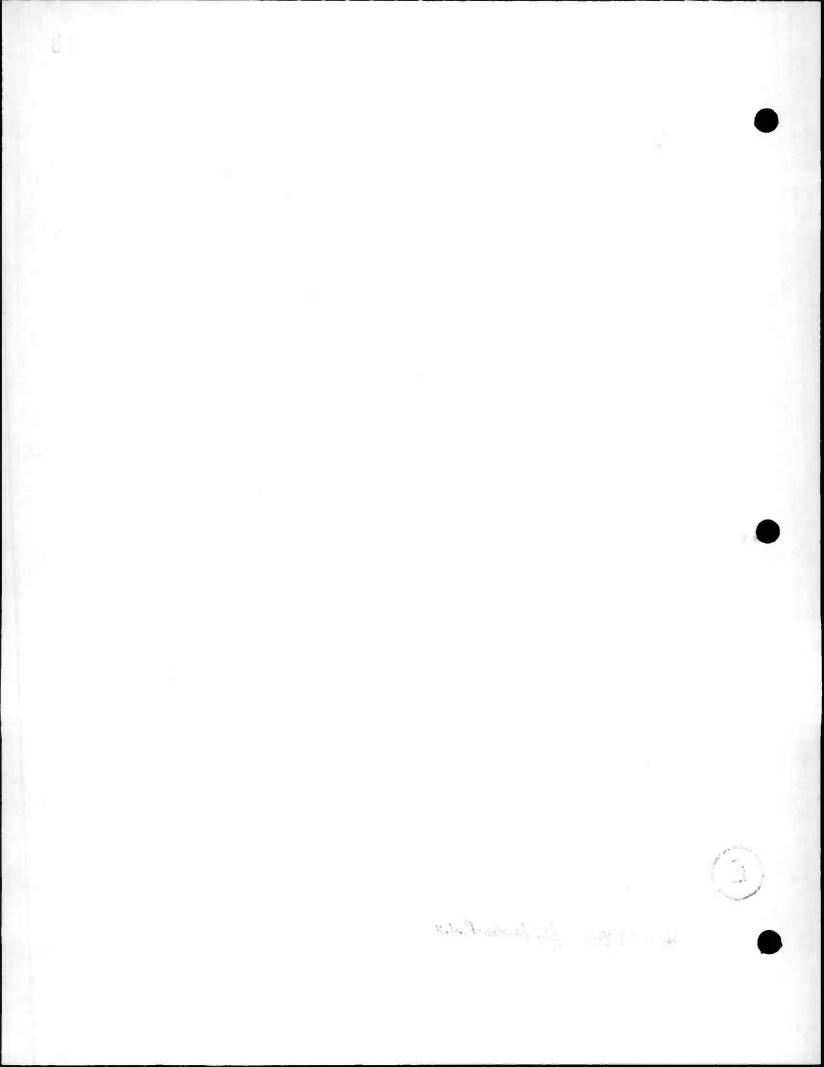
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Should		~	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
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permit. P			Md. 00	LITIMORE		PARKY				1 TYES 2 NO		
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5-0020 nding physician. is the burial-transit			11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVEL FORCES? 1 TYPE IF YES, GIVE WAR DE	S 2 NO	If ye	DECENDENT OF HISPA I, specify Cuben, Mexic YES 2 ND Specif		e or No — 14.	RACE — American Indian, Black, White, etc. Specify;		
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		ETED	15. DECEDENT'S EDU- (Specify only highest grade	completed)	(Give kind o	'S USUAL OCCU If work done durin use retired.)	PATION g most of working	16b. KIND OF BI	JSINESS/INDUST	RY		
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MARYL retained by 5 should be	notified	TO B	19e. INFDRMANT'S NAME (Type/Print)		19b. MAILI	G ADDRESS (St	eet and Number or Rural	Route Number, City or To	wn, State, Zip Coo	· , 21234		
E, N ay be re page 5	be no		KICHARO A. SVI	SR	2919	Know	ACRE UR	INE CAR	5/27/1,	ARYLAND		
S H	must		20e. METHOD OF DISPOSITION 13 Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, crematory of	e OF DISPOSITIO	ENS VERY	5-10 FR	SOSRIC	or Town, State KORYLAGO		
ALTIM death. Page tuneral dire	examiner		21. SIGNATURE OF FUNERAL SERVICE LI	ENSEE			E AND ADDRESS OF FA	CILITY 16	25			
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within hours	event, the medical		23. PART I. Enter the diseases, or shock, or heert feliure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	Liet only one cause or a. APENOCA DUE TO (DR A	aach iine.					Interval Batween		
2 8 E.	traumatic	CERTIFICATION	Sequentielly list conditions, If sny, leading to immediate DUE TO (DR AS A CONSEQUENCE DF):									
BO)		CA	cause. Enter UNDERLYING CAUSE (Diseese or Injury	с,								
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S, P death	7, or	빙		d					<u>-</u>			
3 8 5	any injury,	AL	PART II. Other significent condition	s contributing to deeth	but not resulting	in the under	ying cause given in	Part I. 24a. WAS A		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
Lires that signed by	s any	EDICAL						1 TYES	2 ND	COMPLETION OF CAUSE DF DEATH?		
requir	Shows	Σ								1 TYES 2 NO		
J we	item 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			-	B. PLACE DF DEATH (C)					
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HYSICIA his certi	ked, or	¥	27. MANNER OF DEATH	28a. DATE DF INJUR (Month, Day, Yea	ry 28b, T		. INJURY AT	28d. DESCRIBE HOW	INJURY DCCURE	ED		
ON CON CO CO CO CO CO CO CO CO CO CO CO CO CO	s marked,	ВУ	1 Natural 5 Pending 2 Accident Investigation	(1101111, 20), 1001			WORK?					
TTEN TOR:	28 is	ETED I	3 Suicida 6 Could not be 4 Homicide datarmined	28e. PLACE DF INJU building, atc. (S	JRY — At home, farm (pecify)	, street, factory,	office	281. LOCATION (Street City or Town, State	and Number or R	ural Route Number,		
5 8 8	item	4	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of my kn	owledge, death occu	rred at the time,	data and place, and due	to the cause(a) and me	nner sa stated.			
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외	É	3	296. SIGNATURE AND TITLE OF CERTIFIE	9			29c. LICENSE NU		29d. DATE SIG	GNED (Month, Day, Year)		
2	8 2	7	cherganologie	· ND			D16		> M	24 5, 1995		
<i>)</i> .	7	-	30. NAME AND ADDRESS OF PERSON WH	ARES 2	947 51	PAILL	ST. 8A	LT. MDI	11019			
9			MAY 0 8 1995	A STEELERS OF THE STREET	PURTUE	, , , , , ,	"		4/4/0			
			MAY U O 1999 72									



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

											NEG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH									3. TIME OF DEATH			
		VERDOICA	I HERES			200				MA	/ b.	199	100	11:13 4.W. H
		4. SOCIAL SECURITY NUMBER		AGE (In yrs. les		IF UNDER	DAY8	HOURS	24 HRS. MIN.	7. DATE OF (Month, D	BIRTH Pay, Year)		a. BIRTHPI Country)	LACE (State or Foreign
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3 should		9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				ATH	1	9c. COUN	TY OF DEA	ATH
2,	DIRECTOR	9234 THROGFOORTON KORD				LARRY						BAL	limo	26%
& 	낊	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c. CIT	ITY, TOWN OR LOCATION 10d. INSIDE (IOd. INSIDE CITY					
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physician burial-tra	106. COUNTY 106. CTTY, TOWN OR LOCATION 107. ZIP CODE 108. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 100. CTTY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 101. ZIP CODE 101. ZIP CODE 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or I If yes, specify Cuben, Marken, Puerto Rican, stc.)							or No—	14. RACE -	- American Indian, White, atc.				
		1 Never Married 2 Married	FORCES? 1 [40					n, Puarto Rici	en, atc.)		Black, Specify.	
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	8	17. FATHER'S NAME (First, Middle, Last)	CV.					18. MOTE	HER'S NA	ME (First, Mid	die, Meiden	Sumame)		
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retained to should a should notified	임	19a, INFORMANT'S NAME (Type/Print)		194 G	b. MAILING	ADDRESS	(Street	and Number	or Rural F	Poute Number,	City or Town	n, State, Zip	Code)	याध्यम
. 2 2 0	ı l	20e, METHOD OF DISPOSITION	arson	1	447	1 4	115	001	1210	00 15	0.90	L'A	SUEA	1 IARY IANO
ector, pag		1. Buriel 2 - Cremetion 3 - Ram	oval from Stein	20b. PLACE A	matory or of	OF DISPOSI ther place)	TION (N	Vame of		5-10	20c. LO	CATION —	City or Town	m 1
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death. Pag tuneral di Examiner		1120	> /			5	VA	US C	1977	SILLO F	LIEU	15801	ES .	
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filled in by the on, or removal.		23. PART i. Enter the disesses, or o shock, or heart failure.	omplications that of	caused the de	sth. Do r	not enter	the m	ode of dyi	ing, suct	h aa cardia	or respi	rstory srn	est,	Approximate
fled in the		IMMEDIATE CAUSE (Final	List only one cause	on emon line	74	1	1	11	1	1 0	/ .			intarval Batween Onset and Death
within 24 pletely fille cremation, the		disease or condition resulting in death)	canc	el	1	-	10	ll	be	ada	ler			2445-
ted within completely fall, crematific event, the				OR AS A CONSEC	DUENCE OF	F):	/							
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e be execute sloan and confor to burist traumatic	RTIFICATION	if any, leading to immediate	DUE TO (O	R AS A CONSEC	DUENOE OF	F):		. 1	100					
eath certificate be attending physician mal Hygiene prior ty, or other traur	<u> 2</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury	. Obst.	ruch	. 12		an	ina	7 02					
nding physical program of the progra	Ē	that initiated events resulting in death) LAST	DOE 10 (O	R AS A CONSEC	DUENCE OF	F):								
eath cattend attend ntal Hy	CER		d		-									
E Me e	I 11	PART ii. Other significant condition	a contributing to d	eath but not r	esuiting i	in the und	deriyir	ng csuse g	lven in	Part i. 2	In. WAS AN			VERE AUTOPSY FINDINGS
any are	2	_ Cholana	utis.							١.	PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
3 e o e	MEDICAL									_ [,	1E3 Z	ALT UO		OF DEATH?
sh of	_	DID TOBACCO USE C	ONTRIBUTE	TO CAUS	SE OF	DEAT	Η١	YES 🗆	NO					1 123 2 100
PHYSICIAN: The faw requirements that the State Dept. of H	SICIAN:	25. WAS CASE REFERRED TO MEDICAL				111				eck only one)				
AN: The ficate the State	Sic	EXAMINER?	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER		me 5.54 Ra	aldence	8 Other (S	inacih)			
Sicia sertification of	PHY	27. MANNER OF DEATH	28a. OATE OF IN		28b. TIM	E OF	26c. IN	JURY AT	1	26d. DESCR		NJURY OCC	URED	
	BY F	1 Natural 5 Pending 2 Accident Investigation	(Morith, Day,	rear)	INJ	M		ORK? YES 2	NO					
) 5 4 5 M		3 Suicide 8 Could not be	28a. PLACE OF I	INJURY - At ho	me, term, s	street, lecto	ry, offi	Ica		28f. LOCATI	ON (Street a	nd Number	or Rural Ro	ute Number,
OR ATTENDING DIRECTOR Aber Nours after death them 28 is max	TED	4 Homicide datarmined	ounding, an	e. (apaony)						City or	lown, State)			
2 年 2 2 2	7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of m	y knowledge, de	ath occum	ed at the tir	ne, det	and place	and dua	to the cause	(a) and man	mer en etete	vd.	
PITAL ERAL ERAL ERAL	COMPLET	one) 2 MEDICAL EXAMINE												and manner as stated.
	0.000	29b. SIGNATURE AND TITLE OF CERTIFIER		. /	11			-	NSE NUM					
E 128	B	m	2/1	do	W	or					5			Month, Day, Year)
-	2	30. NAME AND ADDRESS OF PERSON WIT	OCCUMPLETED CAUSE	OF DEATH (ITE	M 27) (Type	Print)		1 4	1 -	, ,		- 1 /	מ צח	1775
7		DR. Rukuno D	inal Ka	RN	10	24	5	141	Ba	210	. 1	6	otho	Md _
_		31. DATE FILEO (Month, Day, Year)	2. REGISTRARY	SIGNATURE	. /	00	7	1 20.	Ne	VA 6-do	ie C	GC.		01215
	•	MAY 0 8 1995 Fel	in dividual	nardall										



3. TIME OF DEATH

10d. INSIDE CITY 1 YES 2 NO

WHAT COUNTRY?

8. BIRTHPLACE (State or Foreig

ar

9c. COUNTY OF DEATH

10g. CITIZEN OF

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for use as the burial-transit permit. Pages 1, 2, 3 should

BE

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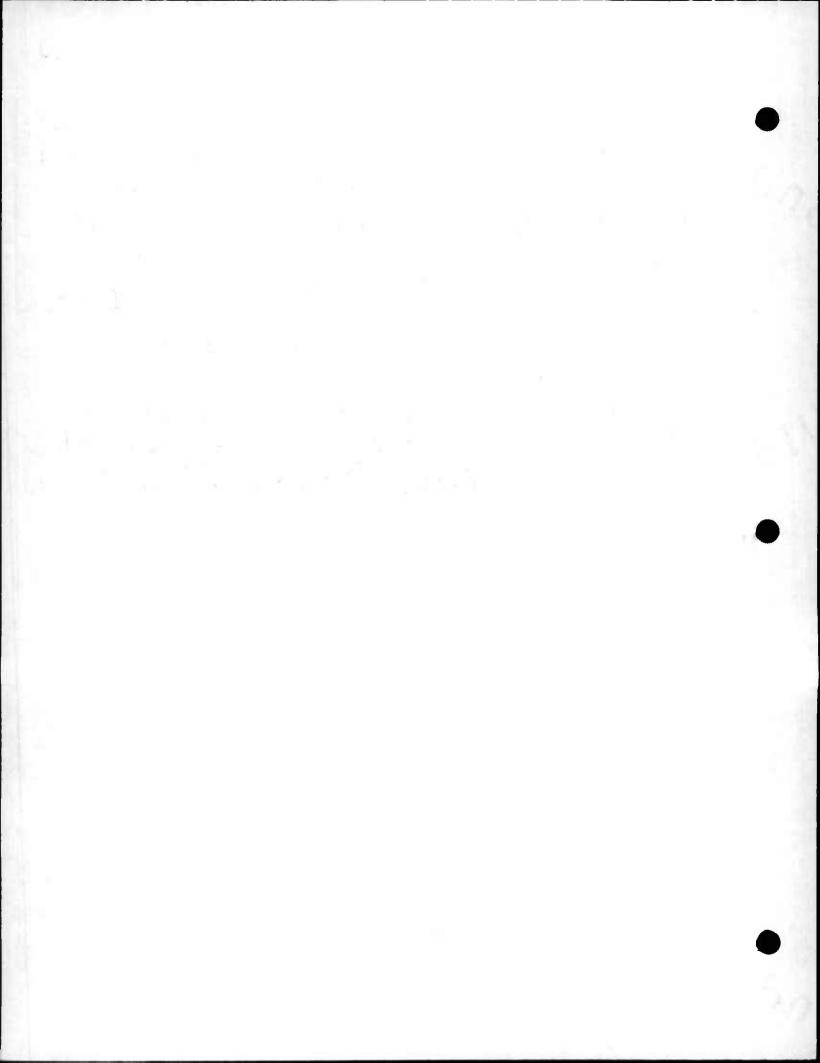
er death. Page 6 may be retained by the hosp	he funeral director, page 5 should be detacheral.	examiner must be notified at once.	
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any mounts after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
G PHYSICIAN: The law requires that the dea	er this certificate has been signed by the at th with the State Dept, of Health and Menta	narked, or Item 23 shows any injury,	
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: After be filed within 72 hours after dea	IMPORTANT: If item 28 is n	

TO BE COMPLETED BY FUNERAL DIRECTOR
MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. CEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Nau 7. DATE OF BURTH A Month, Day, 1991 SECURITY NUMBER 5. SEX 8. AGE (In IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F Mas QR LOCATION OF DEATH 9b. CITY, more 10c. CITY, TOWN OR LOCATION 100. STREET 101. ZIP CODE WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Ouben, Mexican, Puarto Rican, etc.) 1 YES 2 NO Specify: 1 Mover Married 2 Married IF YES, GIVE WAR OR DATES Widowed 4 Divorced 3 M 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ary (0-12) e (1-4 or 5+) -000 Prvice anager 17. EATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (FIRST NAME (Type/Print) 19b. MAILING ADDRESS (Str. 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of 4 Donation 5 Other (Specify) 1101 22 NAME AND ADDRESS OF MACILITY JOSEPH L. RUS 12 ock, or hear failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition 315 resulting in death) DUE TO (ON AS A CONSEQUENCE OF): Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Ni HOEND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH COMPLETED BY PHYSICIAN: YES | NO | UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 YES 2 NO 1 Department 2 ER/Outpatiant 3 DOA 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Netural I YES 2 NO 2 Accident Investigation 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

nter the diseases, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, Approximata Interval Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 TYES 2 THO 28d. DESCRIBE HOW INJURY OCCURED 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 29a. CERTIFIER (Check only 2 [MEDICAL EXAMINER ice, end due to the cause(a) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Mau 0 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri 32 REGISTRAR'S S OHMH-16 Rev 1/69



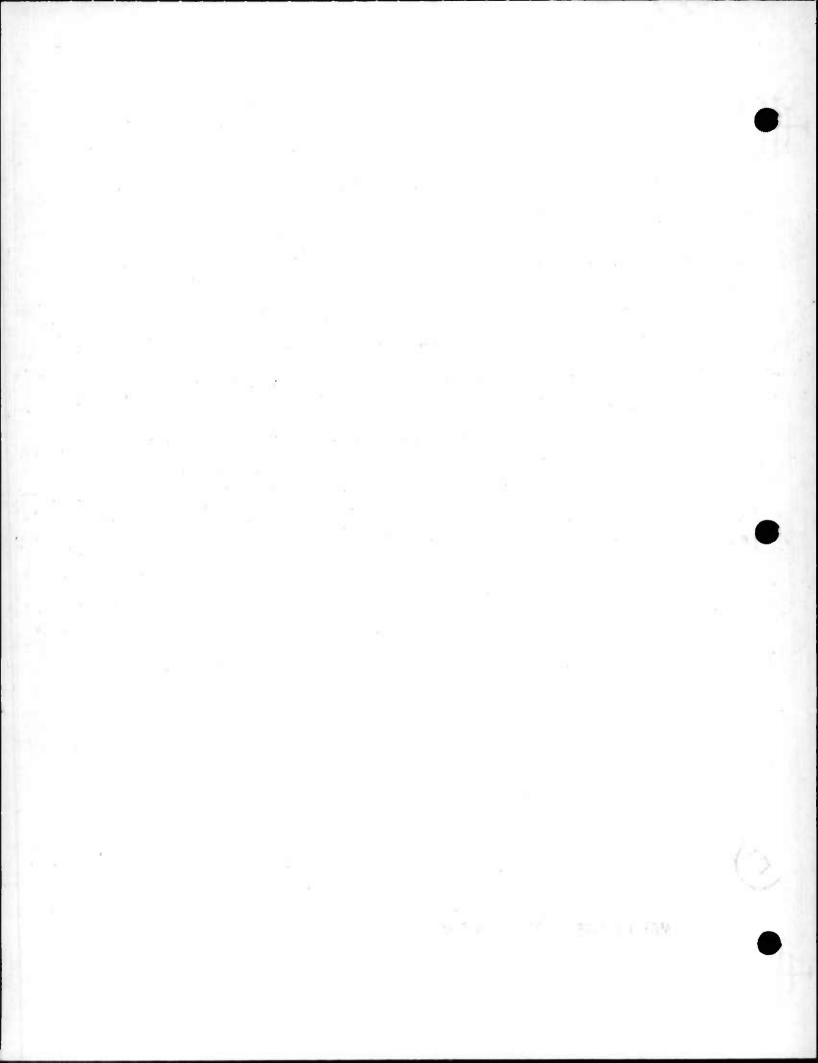
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DIVISION OF VITAL RECORDS, P.O. BOX 687	-1
	INSPITAL OR ATTENDING PHYSICIAN: The I
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32 REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Edythe Gertrude 1;50 A. Filbert May 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) NOVEMBER IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 215-01-5102 92 DAYS 1 M 2 XF 3,1902 Virginia nouns when death. Page 6 may be retained by the hospital or attending physician. and in by the furnish director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Meridian Nursing Center- Hamilton Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 - YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1801 Forrest Road 21234 S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Bieck, White, etc. 1 Never Married 2 Married Specify: White BY 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5 +) Co. 12 Personnel Schleiser Dept. 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Malden Surname) Reginald Noel BE Pendelton Mary Garthright notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ellwood N. Filbert Same as 10e 9 20a. METHOD OF DISPOSITION
1 (X Burlal 2 □ Cremation 3 □ Ra 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State Must Moreland Mem. Pk. 5/8/95 Baltimore, Maryland examiner 21. SIGNATURE OF 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. ne filled in by the fillen, or removal. 5305 Harford Road - Balto Md medical 23. PART I. Enter the disease Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final **Onset and Death** cremation other traumatic event, the disease or condition_ Ineten completely resulting in death) DUE TO (OR AS A CONSEQUENCE OF) and com o bunial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury Mental Hydiene DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST attending 0 injury, signed by the a Health and Men PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 YES 2 NO peen of PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem State certificate HOSPITAL: OTHER 1 YES 2 .NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA rsing Nome 5 Residence 8 Other (Specify) 4 CHE the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, E. this 1 Watural 1 YES 2 NO BY Investigation death 2 Accident LERAL DIRECTOR...
The hours after death DIRECTOR: After 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide IMPORTANT: If item 29e CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. ation end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIEF 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day. Year) 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Howard Bond M.D 9618 Belair Road -21236



DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

1. DECEOENT'S NAME (First, Middle, Last)

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	1 8	1. DECEGENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF OEATH												3. TIME OF OEATH		
		Grace S. Fost 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In										May 4, 1995				12:15 P. N
		215-82-601		1 M 2 F	"ALC		VRS.	IF UNDE	DAYS	HOURS	MIN.		Day, Year)	<u>, </u>	Country	
pino		9a. FACILITY NAME (If not institution, give si		77 71		1	The.			ORLOCAT	ION OF D		30-19			ryland
physician. burlal-transit permit. Pages 1, 2, 3 should	DIRECTOR	1033 Marleigh Circle						96. CITY, TOWN OR LOCATION OF DEAT					ATH Sc. COUNTY OF DEA			
es 1,		RESIDENCE OF DEC	10b. COUNT	γ			10c, CIT	y, TOWN	OR LOC	ATION					-	10d. INSIDE CITY
. P20	E	Maryland	Bal	timore				rimo							1	LIMITS?
E	ME	10e. STREET AND NUMBER							-10	of, ZIP COD				10g. CITI		HAT COUNTRY?
an. Transit	FUNERAL	15 Evans Ave.					21093								J.S.A	•
ding physician the burlat-tra	BY	11. MARITAL STATUS 1 Never Merried 2 Married Married			2 3N	INMED 13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Mexic 1 YES 2 NO Spec					an, Puerto Rican, atc.)			14. RACE — American Indian, Black, White, atc. Specify: White		
or attending r use as the	E	15. DEC (Specify only	EOENT'S EDU y highest grade	CATION completed)		16a. DEC	EDENT'S	USUAL C	CCUPAT	ION lost of worki	ing.	16b. i	(IND OF BUS	SINESS/IND	USTRY	
by the hospital or attending be detached for use as the at once.	COMPLETED	Elementary/Secondary (0		College (1-4 or 5	+)	IIIo.	lomen	e retired.)		COL OF WORK	''y		Own :	Home		
by the hospital 1 be detached to 1 at once.	BE CO	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Sinclair														
5 should notified	TO B	19a. INFORMANT'S NAME (7. Melville T.		er, Jr.		19b.	MAILING 1033	ADDRES Ma:	s (Street	and Numbe	or Aural I	Route Number	City or Town	n, State, Zip Md .	Code) 2120	4
teath. Page 6 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSITI	ION in 3 - Ram	oval from State	20b	PLACE A	ND DATE C	F DISPO	SITION (A			DATE	20c. LO	CATION —	City or Tow	
Page al dire		21. SIGNATURE OF FUNERA	L SERVICE LIC					22.	NAME /	NO ADDRE	SS OF FA	CILITY				
death. Pag tuneral dii I. examiner		Ruck Towson Funeral Home, Inc.														
hours after of in by the or removal.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resolvatory errest.														
E 6 €		shock, or haart failure. List only one cause on each line.									Interval Between Onset and Death					
completely iai, cremati event, t				DUE TO	(OR AS A	CONSEC	UENCE OF):			11					
ertificate be executed ing physician and con giene prior to burlai, other traumatic er	ATION	Sequentially list conditions, if any, laading to immediata OUE TO (OR AS A CONSEQUENCE OF):														
이 전수 느	CERTIFICATION	CAUSE (Disease or Injury that initiated events reaulting in daath) LAST														
e atten Aental H		PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY. 24b. WERE AUTOPSY FINDINGS														
aw requires that the death is been signed by the atteit pr. of Health and Mental is shows any Injury, or	MEDICAL	- Ottal arginica	THE CONGRESSION	a contributing to	Gaath D	ut not re	auiting i	n the ur	nderlylr	ig cause	given in		PERFOR	MED2		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
been of b		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE O	F DEAT	H YE	SП	NO [7 UNG	FRTAIN	<u></u>				T YES 2 NO
- 88 6	IAN	25. WAS CASE REFERRED TO EXAMINER?				26. PLACE										
SICIAN: The law r certificate has be the State Dept.	PHYSICIAN:	1 TES 2 10		HOSPITAL: 1 Inpatient 2	ER/Outp	etient 3	DOA	OTHEI		no 5 D	sidence	6 Other (Specily)			-
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State Liem 28 is marked, or item	ву РН		ANNER OF DEATH 288. OATE OF INJURY (Month, Day, Veer) 28b. TIME OF INJURY WORK? M 1 YES 2 NO									URED				
OR ATTENDING PHYS DIRECTOR: After this hours after death with Item 28 is marked		3 Suicide 8 Could not be detarmined 26a. PLACE OF INJURY — At he building, atc. (Specify)					me, farm, atreet, factory, office					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
1000	COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, sets and place, and due to the cause(a) and manner as stated.														
MPORTANT	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. MCENSE NUMBER 29d. DATE SIGNED (Modit, Day, Year)														
28 8	TO	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DE	ATH (ITEM	27) (Typ	Pfint)	_	Щ) 2	7 49	88	•	1/4	193
1	-	Paul Riva					l, Liy	the	rvil	le, l	Mary.	land 2	21093		1 /	
10		MAY 0 8 195	95 Ja	Li Austra	R TENE	E	7	0								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REG. NO.

BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm with the State Dear of Hashib and Marrial Huriana notor in burial companion or general
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OF VITAL RECORDS, P.O. BOX 68760	uted wit	comple
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FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH John 10:10 A m Edward Frank May 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) 1 X M 2 | F 49 1945 July 17, 220-42-7172 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 6013 Snowdens Run Road (Home) Sykesville Carroll County RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll County Sykesville 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6013 Snowdens Run Road 21784 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: RACE — American Indian, Black, White, sic. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced Army Reserves White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INOUSTRY (Specify only higher Elementary/Secondary (0-12) College (1-4 or 5+) 4 Trust Officer Banking 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Joseph Frank 70 Helen Groh BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cheryl A. Frank (Wife) 6013 Snowdens Run Road Sykesville, MD 21784 must be 20s. METHOD OF DISPOSITION
1 № Burisl 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Lake View Cemetery 5/8/95 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Brian HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 medicai 23. PART I. Enter the diseases, or complications tild caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition Lung 18 months CANKER event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Kioney 3 months traumatic FAILURE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury HYPERTENSION
DUE TO (OR AS A CONSEQUENCE OF): 3 months other that initiated events resulting in death) LAST 6 in uny, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL requires that 1 been signed by of Health and any COMPLETION OF CAUSE 1 - YES 2 14 NO OF DEATH? 1 YES 2 NO has been Dept. of I PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES YOU UNCERTAIN NDING PHYSICIAN: The law 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL certificate h HOSPITAL: OTHER: 1 | YES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 M Residence 6 Other (Specify) 6 26s. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH this c. 26b. TIME OF 26c. INJURY AT 26d. OESCRIBE NOW INJURY OCCUREO is marked, 1 Natural 1 YES 2 NO ВҰ After death 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be CIOR 4 Homicide 29s. CERTIFIER

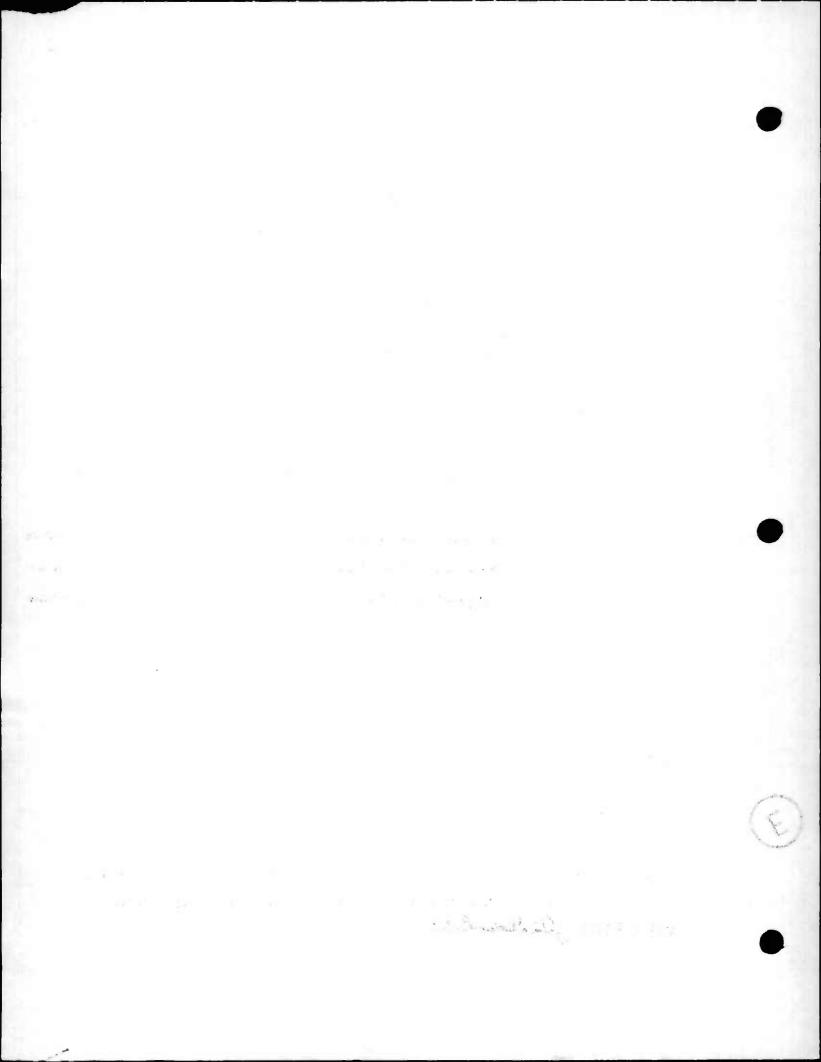
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1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar se stated. IMPORTANT: 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 물 물을 remb D. Howards D 5/5/95 44636 223 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 711 W. 40 M Street BALTIMORE MD Frank D. HOWARD 21211

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

MAY 0 8 1995

NO



BALTIMORE, MARYLAND 21215-0020	ertificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	no physician and completely filled in by the funeral director, page 5 should be detached for use as the buriaters
SALTIMORE, MA	death. Page 6 may be retain	e funeral director, page 5 sho
O. BOX 68760	be executed within 24 hours after	ician and completely filled in by the
O. B(ertificate	no physic

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

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				ierson					MAY 1,	199	75 4:50 AM
			4. SOCIAL SECURITY NUMBER		(In yrs. lest birt	MONTHS		F UNDER 24 HRS. OURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
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	pinous	~	9n. FACILITY NAME (If not institution, give st		1	9b. CITY,		OCATION OF DEA		9c. COUNT	Y OF DEATN
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	- ×2	2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		1.00	Oc. CITY, TOWH OF					
	permit. Pages	DIR	MARNIANA	NIA		oc. orr, rown or	4		0-		10d. INSIDE CITY
	mit.		10e. STREET AND NUMBER	/- //-			-	TIMO	RE		1 YES 2 NO
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, a	tran	N.	11. MARITAL STATUS SINGIC					212			15 A.
120 Presi	burial-transit		1 Never Married 2 Married	12. WAS OECEDENT EVER I FORCES? 1 YES	2 NO	if	yes, specify	y Guban, Maxican	C ORIGIN? (Specify Yes, Puerlo Rican, atc.)	or No 14	I. RACE — American Indian, Black, White, atc.
9	age age	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR O	DATES	1	YES 2	XNO Specify:			Specify: BIACK
AND 21215-0020	for use as the	ED	15. DECEOENT'S EDUC		18a. DECED	DENT'S USUAL OCC	UPATION		16b. KIND OF BUS	SINESS/INDUS	0-11-1
212	or us	ET	(Specify only highest grade Elementary/Secondary (6-12)	College (1-4 or 5+)	(Give ki	nind of work done du NOT use retired.)	ring most of	f working	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
D	per li	COMPL	10+HGRADE	conege (1-4 or 5 +)		LAB	ORE	ER	ATA	011 5	PILL COMPANY
Z	detached	O	17. FATHER'S NAME (First, Middle, Last)			2/10			E (First, Middle, Maiden		PITEL COMPANY
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MARYLAND 21215-0020 retailed by the hospital or attending physic	5 should notified	BE	19a. INFORMANT'S NAME (Type/Print)				Street and I	Number or Rural Ri	oute Number, City or Tow		
	10 TO	5	CLARA FO	IERSON	44	161 E1	DAN	EPN		RE, M	
BALTIMORE, er death. Page 6 may be	funeral director, page xaminer must be		20a, METHOD OF DISPOSITION	201	b. PLACE AND	DATE OF DISPOSIT	ION (Name o	of of			ly or Town, State
ALTIMORE death. Page 6 may	must		1 Burial 2 Cremation 3 Remo	val from Stata	metery, cremato	ory or other place	KM.	CTERV	659 B		MORE, MD.
2 %	al di		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. N	AME AND A	ADDRESS OF FAC	BROWN J		INERAL HOME
eath .	tuneral din I. examiner		▶ (\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	() m)	10.	SEP	H H, I	BROWN J		
B/B	o = o	-	22 DADY I Franch discuss	17.101		114	13 W), BALT	IMORE ST	BAL	TO. MO, 21223
hours	.=		23. PART I. Enter the diseases, or cashock, or heart fellure. L	iat only one ceuse on e	d the death. each line.	. Do not enter t	ne mode	of dying, such	as cardiac or respi	rátory arres	t, Approximata interval Between
42 A	E 9 E		iMMEDIATE CAUSE (Fine) disease or condition	0 1 -	100	- 1	20				Onset and Death
	cremation, rent, the		resulting in death)	10 118	V (1	and C	176	eaco			1 year
68760 ecuted wil	S - 60			DUE TO (OR AS	A CONSEQUER	NCE OF):					
68 86cut	at pr	8	Sequentielly list conditions,	DUE TO (OD 10							
BOX	ysician a prior to traum	ATI	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	K CONSEQUEN	NCE OF):					
Eafe D	e B	CERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	A CONSEQUEN	NCE OF:					
O. Arting	attending ntal Hygie Y, or otl	토	resulting in death) LAST			31,					j
S, P.O. Bo	the atter Mental Ijury, o	B									
ă ă	- 0	AL	PART II. Other aignificent conditions	contributing to death b	out not reeui	iting in the und	erlying ca	ause given in P	art i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
RECOR	signed b Health ar	MEDICAL							1 YES 2	11	AMILABLE PRIOR TO COMPLETION OF CAUSE
E C	r signed F Health OWS an	W.								A	OF DEATH?
- >	has been Dept. of 1 23 sho	ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE C	OF DEATH	YES N	0 🗆 1	UNCERTAIN			
TAL	State De	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER2.			F DEATN (Check on					
VITAL AN: The lav	certificate to the State 1, or Item	Si	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	patient 3 🗆 🗅	OOA 4 SMirsin	g Home 5	Residence 6	Other (Specify)		
OF	with th	PHY	27. MANNER OF DEATN	26a. DATE OF INJURY (Month, Day, Year)	26		8c. INJURY WORK?	AT	28d. DESCRIBE NOW II	JURY OCCUP	RED
Z	fter this cath with marked	ВУ	Natural 5 Pending Investigation	(moran, bay, roar)		M		2 NO			
O NO	R: After ir death is ma		3 Suicide 6 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— Al home, I	farm, street, factor	y, offica		281. LOCATION (Street a	nd Number or	Rural Route Number,
IVISION OF VI	DIRECTOR: nours after fem 28 i	2	4 Nomicide detarmined		J.,				City or Town, State)		
1	DIREC hours	1 2	29a. CERTIFIER Check only	TAN: To the best of my know	rledge, death o	occurred at the tim	e, data and	piece and due to	the cause(s) and man	oer ee eleled	
L E	22.11	COMPLETED									ause(s) and manner as stated.
(E	TO THE BE filed within 7 IMPORTANT:		296. GIGNATURE AND TITLE OF CERTIFIER	()				c. LICENSE NUME			
	P lied	H	01110-0	dla 1			-	LIVIO	NILI D	DATE S	GNED Month, Day, Year)
2	₽2₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27)	(Type, Print)		1111	110	-7	1,1,7
_	_		CV Plane MD	2. T. 24 VM	De-		Ses	Thurs	Hook inc.	Hisalt.	2018, 14 Silver
	5		31. DATE FILED (Month. Day, Year)	32. BEGISTRAR'S SIGN	ATURE	-> N/250	565	-0 KV>	Malaking	Harly	lan Dar Hann
			MAY 0 8 1995 A	hi develor Re	dall						
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3. TIME OF DEATH

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FOR STATE REGISTRAR

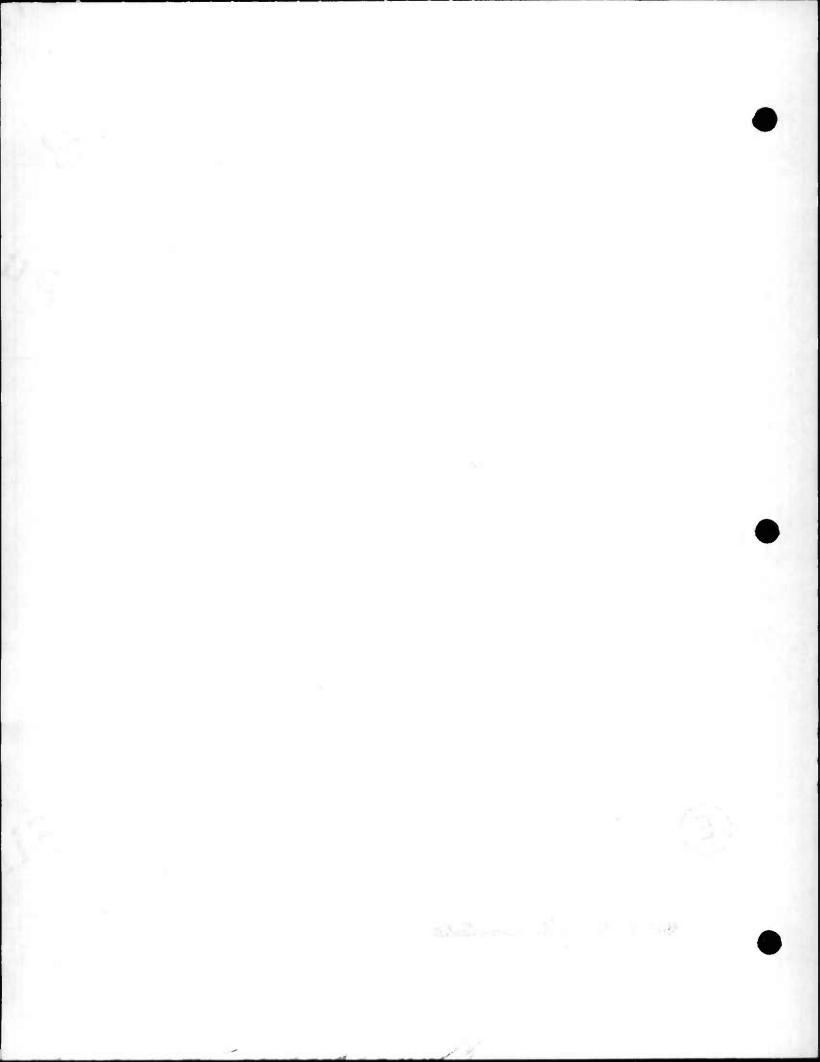
1. DECEDENT'S NAME (First, Middle, Lust)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

2. DATE OF DEATH YEAR Thomas
4. SOCIAL SECURITY NUMBER May 06 1995 Howard TT CARRETT 11:00 7. DATE OF BIRTH (Month, Day, Year 6. AGF. (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 233-58-4003 DAYS HOURS 1 M 2 F 55 OCT 1, 1939 North Carolina Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Franklin Square Hospital Essex Baltimore County RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10h COUNTY 10d. INSIDE CITY Maryland Harford permit. Joppatowne 1 YES 2 NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10e, CITIZEN OF WHAT COUNTRY? 421 Barksdale Road funeral director, page 5 should be detached for use as the burial-transit 21085 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuben, Maxican, Puerto Rican, etc.)

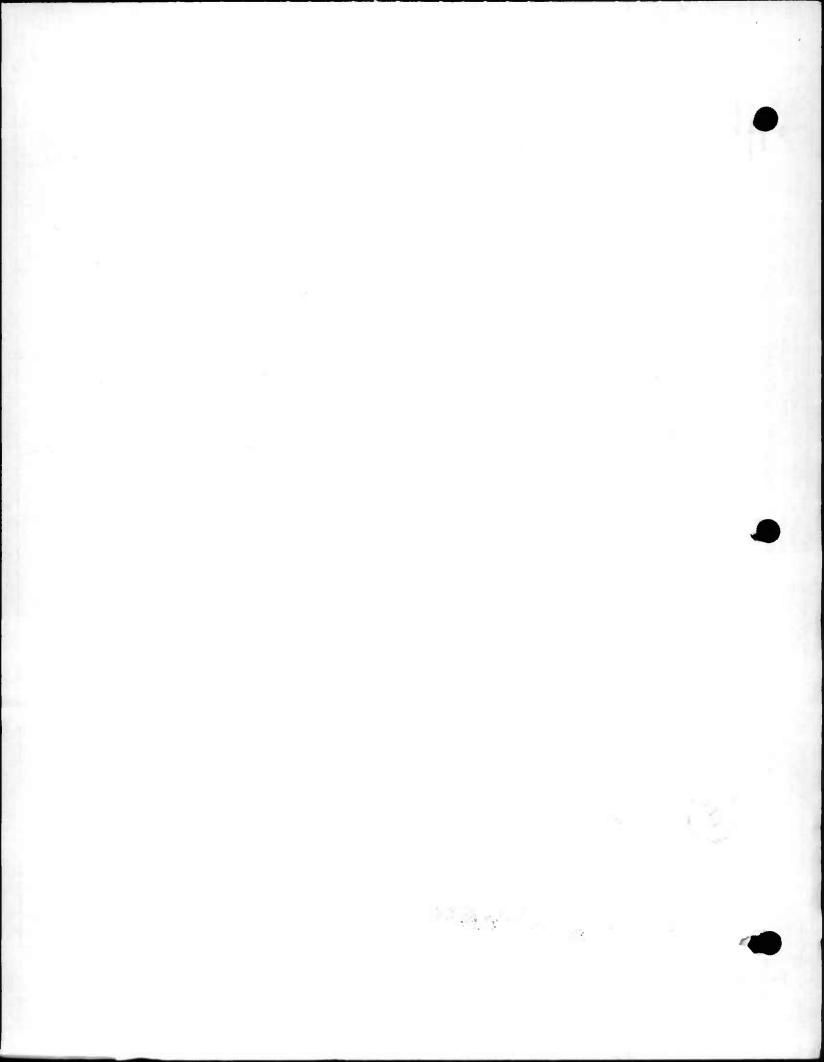
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married YES, GIVE WAR OR OATES Specify: White В 3 Widowed 4 Divorced 16a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY pecial Assistant to the Dir. of Elementary/Secondary (0-12) College (1-4 or 5+) University of Maryland Parking Facilities At Baltimore 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname, Thomas Howard Garrett, Sr. notified at Gray Howell BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Phyllis A. Garrett 421 Barksdale Rd. Joppatowne, MD 21085 9 20a. METHOD OF DISPOSITION
1 ☐ Burlet 2 ⚠ Cremation 3 ☐ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must Metro Crematory, Inc. 05/08/95 Baltimore, MD 4 ☐ Donation 6 ☐ Other (Specify) examiner 21. SIGNATURE OF NUNERAL SERVICE TO INSEE Cremation Society of Maryland George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 removal. medicai 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, filled in by Approximate shock, or heart failure. List only one ceuse on each lina. Interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death the disesse or condition resulting in dasth) and completely fi to burial, cremation Pneumonia event, hours DUE TO (OR AS A CONSEQUENCE OF): Probable Aspiration traumatic CERTIFICATION 2 hours Sequantistly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If sny, leading to immediata cause. Enter UNDERLYING signed by the attending physician a Health and Mental Hygiene prior to requires that the death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST 6 PART II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? any 1 TES 2 NO shows a OF OEATH? 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN PHYSICIAN: has b. Dept. OR ATTENDING PHYSICIAN: The law DRECTER: After this certificate has brount after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tem HOSPITAL: OTHER: 1 TYES 2 NO 1 N Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify) 6 27. MANNER OF GEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26b. TIME OF marked, 26d. DESCRIBE HOW INJURY OCCURED 1 X Netural 5 Pending investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 ED 6 Could not be 4 Homicide 23 detarmined CONTRA 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HUNEPAL D TO THE FLINEPAL D DE TIND WITH Z TO IMPORTANTE II III 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BB Llyson 14 95 0 36. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Stacey Dyson 9000 Franklin Square Drive Baltimore OATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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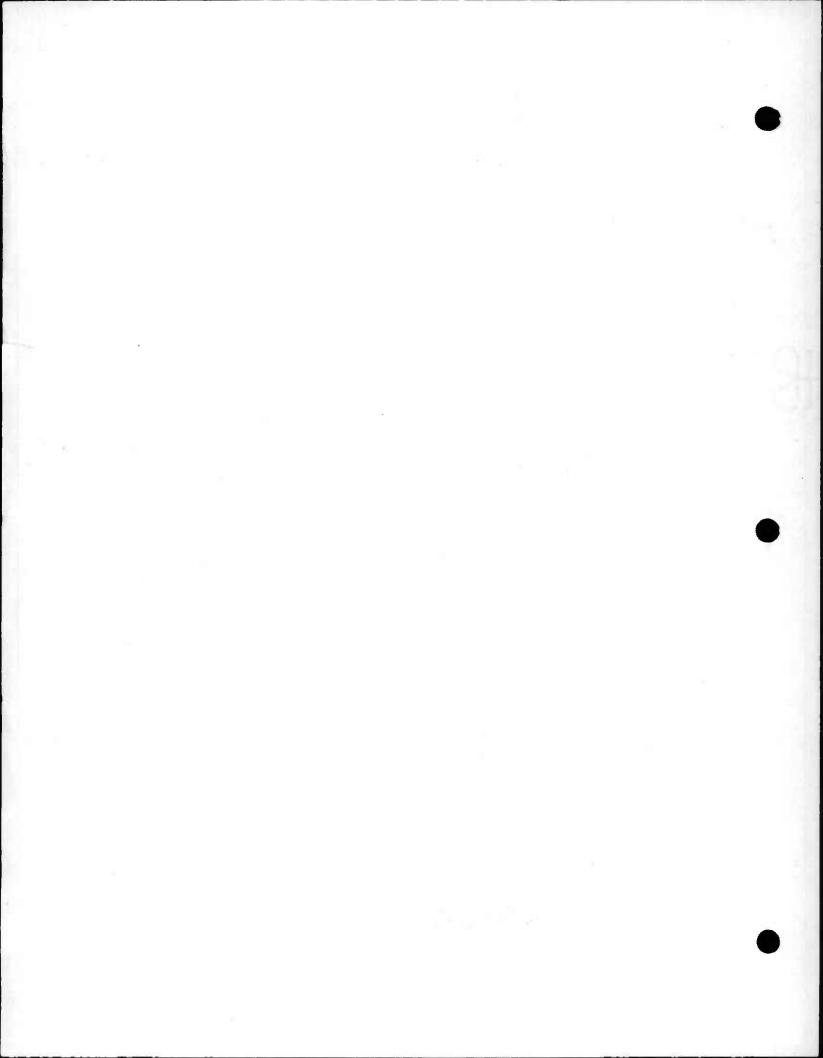
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SVARS , SR James GUY May 6,1995 8:00 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 17 M 2 | F 12 BIYA PARY Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR HOSPITA RAG CLACIZZON Baltimore RESIDENCE O CEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ARYLAND BALTIMORE ā permit. 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit LABLRRY 9503 AN 21234 .A hours after death. Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Maxican, Puerto Ricen, atc.) 1 Never Married 250 Merried YES, GIVE WAR OR DATES 1 TYES 2 TO NO ¥ Specify n by the funeral director, page 5 should be detached for use as the removal. 3 Widowed 4 Divorced I.w.w. 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY nentary/Secondary (0-12) College (1-4 or 5+) scironic ART once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, notified at HIR BE 1/2 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street 2634 State, Zip Code 2 HRY Q AND A be METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 20c LOCATION - City or Town, State DATE Buriel 2 Cremetion 3 en S D Other (Specify) LAN examiner 22. NAME AND ADDRESS OF FACULITY SVANS CHAPLE 21. SIONATURE OF FUNERAL BERVICE LICENSEE OF FORD the medical filled in by 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or haart fallure. List only one cause on each line 6 Interval Between IMMEDIATE CAUSE (Final Onset and Dasth cremation, disesse or condition ____ has been signed by the attending physician and completely in Dept. of Health and Mental Hygiene prior to burlal, crematic s. Small cell carcinoma of lung lyear event. executed with DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be a TO THE PUREFAL DIRECTOR. After this certificate has been signed by the attending physician is find within a figure of the state Dept. of Heath and Merital Hygiene prior to IMPORTANE. If you shall have some state manked, or from 23 shows any Injury, or other traum cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 Ainpatient 2 ER/Outpatient 3 OTHER DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year, TIME OF 28c. INJURY AT WORK? 28b 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident BY 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 品 8 Could not be 4 Homicide 9a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, and due to the cause(s) end manner es stated. (Check only one) mination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Loran 5.695 R D 1775 0 30. NAME AND ADDRESS OF PERSON WHO DIFFLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9000 Franklin Square Dr. Baltimore, Maryland 21237 Dr. Nimish Gosrani MAY U 8 1995



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Vickie Jean Hathield 4 P. pril 20 1995 7. DATE OF BIRTH
(Month, Day, Year)
AILA. 31, 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 F 214-50-2573 43 YRS. Aug. Maruland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give etreet end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO Maruland Prince George College Park permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 5217 Iroquois Street 20740 USA burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify: White 3 Widowed 4 Divorced the ass 8 15. OECEDENT'S EOUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY USe (Specify only highest COMPLET College (1-4 or 5+) Ď Elementary/Secondary (0-12) 12 page 5 should be detached Office Manager Furniture notified at once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Dudley Roberta Updike 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Thomas Hathield 5217 Iroquois Street, College Park, Maryland 20740 9 must l 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State funeral director, Maryland Veterans Cemetery 4/24 Crownsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LIDENSEE 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home. Inc. 7601 Sandy Spring Road, Laurel, MD 2070; the the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. Liet only one cause on each line. filled in by Approximate Interval Between cremation, or IMMEDIATE CAUSE (Fina Onset and Death EISEN MENGERS , YNDROME disease or condition completely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): ATRIAL SEPTAL DEFECT anding physician and con Hygiene prior to burial, CERTIFICATION Sequentielly list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other t thet initiated events DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. resulting in death) LAST 6 Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL has been signed by the Dept. of Health and I shows any 1 TYES 2 TAO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law ITO THE FUNEPAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 s 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 1 16 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural t YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the of axamination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end menner ee stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month. Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CTOR OLESVILLE



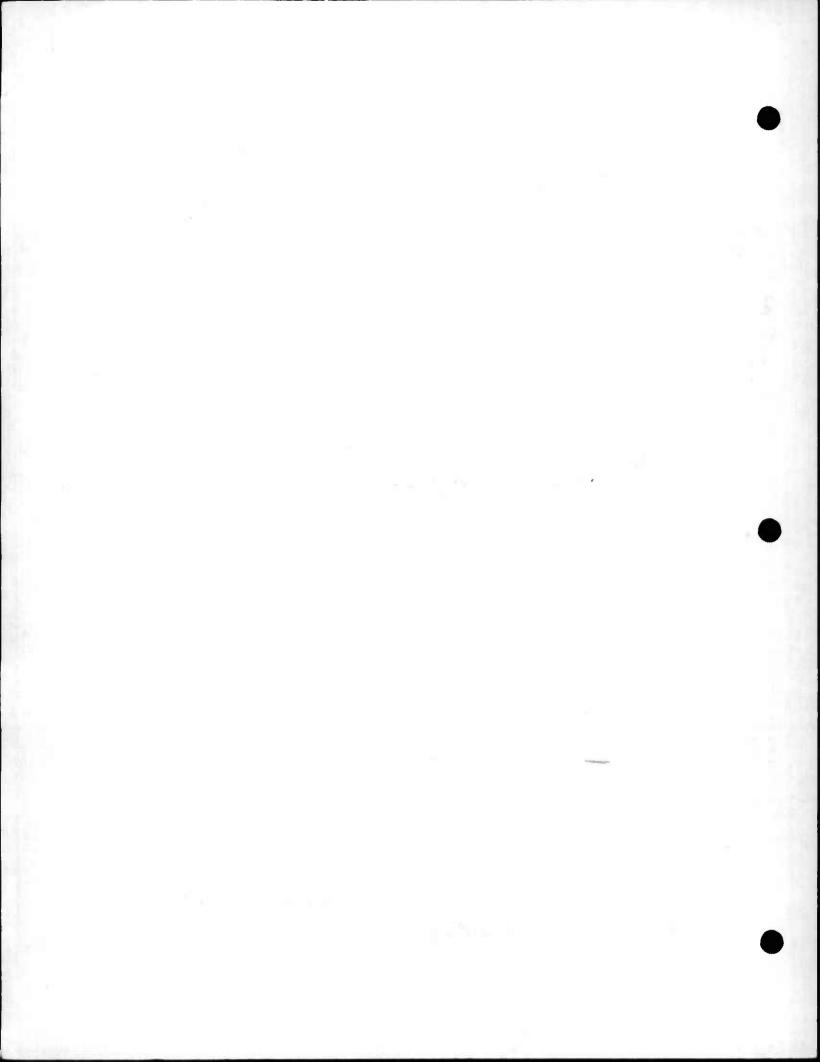
B.K.S

ITEMS: 23 PART I. 27, PER MEO FILM G-724 6/5/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY SHAWN Μ. HEAKIN 1995 5, 1525 MAY PM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) April 15, 1964 6. AGE (In vrs. last birthday IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 214-90-7531 DAYS 31 1 XX 2 - F MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, YOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 835 WEST LOMBARD STREET DIRECTOR n/a BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY n/a Baltimore City permit. XYES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and Mental Hygiene prior to burial, cremation, or removal. 835 W. Lombard Street 21230 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES X2 160 IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-It yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 Never Married 2 Married BY 1 YES ZONO Specify Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Disabled 12th n/a 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) # Oliver Heakin Charlotte F. Gardner BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Charlotte F. Heakin 12 W. Fort Avenue, Baltimore, MD 21230 pe 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must □ Donation 8 □ Other (Specify) Voshell Mem. Gardens, 1995, May Baltimore examiner RE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore, MD2123D medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line interval Between **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition resulting in death) SCHIZOPHRENIA event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated evente regulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: has by Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL: OTHER: XXYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 🖟 Residence 8 ☐ Other (Specify) 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 286. 28c. INJURY AT marked, 28d. DESCRIBE NOW INJURY OCCURED this with 1 XX Natural 1 YES 2 NO BY After 1 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 6 Could not be DIRECTOR: A hours after d 4 Homicide datermined COMPLET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 h (Check only one) HOSPITAL 2 XIMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year)

MAY 6, 1995 BE A Wright MO O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 DONALD WRIGHT MD G. 1995 REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

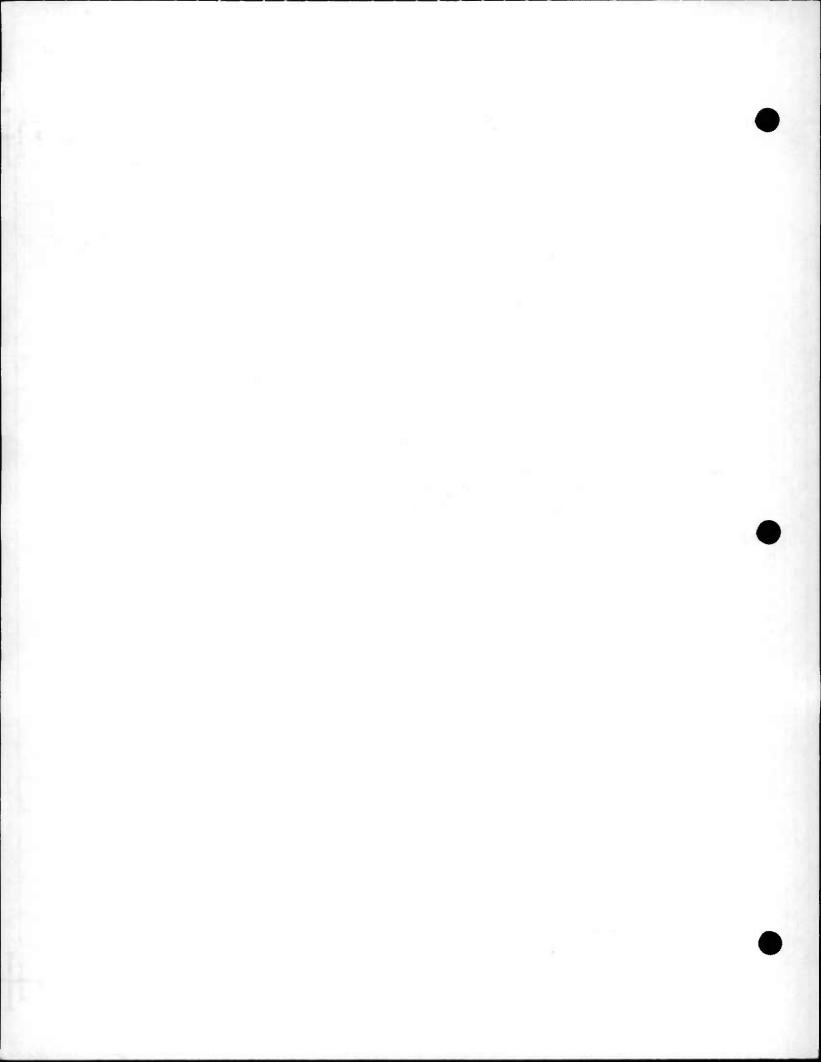


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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2 DATE OF DEATH 3. TIME OF DEATH Roger Jones MAY 6:22 Am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign SEPT. 20, 1939 1 💹 M 2 🗌 F 55 193-28-5548 PENNSYLVANIA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE DIRECTOR RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY D.C. N/A WASHINGTON 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 620 7TH STREET, N.E. 20002 wern mector, page 5 should be detached for use as the burial-transit USA the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Mexican, Puerto Rican, stc.) 1 — YES 2 📉 NO Specify: 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced WHITE KOREAN COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16s. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 PRINTER US GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ after death. Page 6 may be retained by WILLIAM JONES MARY CAFFREY BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JEANNE JONES 620 7TH STREET, NE, WASHINGTON, DC 20002 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stats OATE must 1 □ Burlai 2 ☑ Cremation 3 □ Removal from Stats
4 □ Donation 5 □ Other (Specify) Cometery, Crematory or other place;
BALTIMORE-WASHINGTON CREMATORY 5/3 LAUREL. MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADORESS OF FACILITY FLECK FUNERAL HOME, INC. n by the A 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 medical no not enter the mode of dying, auch as cardiac or reapiratory arrest, filled in by Approximata ock, or heart fall List only one cause Interval Betwe IMMEDIATE CAUSE (Finsi Onaet and Death the cremation, disease or condition resulting in death) · Metastatic 94 an creas completely dooma event, DUE TO (OR AS A CONSEQUENCE OF): in and com to burial, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata attending physician ntal Hygiene prior to Pe cause. Enter UNDERLYING certificate CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atter Injury, PART II. Other aignificant conditions contributing to death but not resulting in the undariying cause given in Part I. the MEDICAL 24a, WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE signed by the Health and N any enal 1 TYES 2 THO OF DEATH? requires Shows 1 TES 2 NO t of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I UNCERTAIN CIAN: has by Dept. AMP. 23 25, WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL:
1. Inpetient 2 - ER/Outpetient 3 - DDA OTHER: OR ATTENDING PHYSICIAN: 1 TES 2 NO PHYSI 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT TIME OF 28d. DESCRIBE HOW INJURY OCCURED. marked. 1 Natural 5 Pending After the 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 DIRECTOR: A ETED a Could not be 4 Homicide 28 detarmined COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND/TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 3181 5-2-95 20 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ave T-1 R.G. BHOJRAJ. Laurel MD 2070 04 Gorman 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

ITEM: 12. PER F.H. FILM G-723 5/8/95 t.t



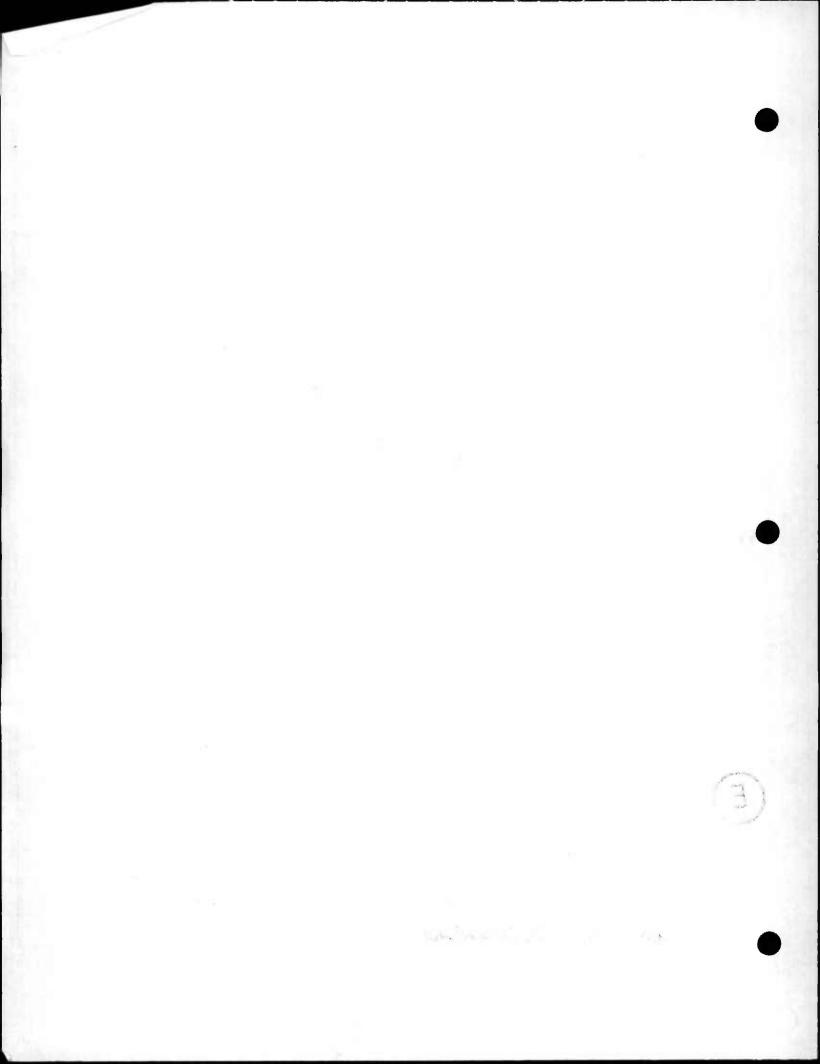
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH EVA Jones 15 PM M may 7. DATE OF BIRTH (Month, Day, Year) APRIL 18 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. A. BIRTHPLACE (State or Foreign 75 MARYLAND 216-16-8409 1 M 2 X F APRIL 1920 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Burnie NORTH ARUNdel Arundel Hospital Anne RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY GLEN BURNIE ANNE ARUNDEL MARYI AND 1 YES 2 NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 105 HIGHLAND ROAD the funeral director, page 5 should be detached for use as the burial-transit 21060 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, While, etc. 1 Never Married 2 Married A Specify WHITF 3 Wildowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5 +) HOMEMAKER HOUSEHOLD once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **JOSEPH** notified at WITZI FR BE MARY BUCKHITZE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ELMER C. JONES SR. 105 HIGHLAND ROAD GLEN BURNIE, MARYLAND 21060 9 20a. METHOD OF DISPOSITION
1 X Burlal 2 ☐ Cremalion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must MARYLAND VETERANS CEMETERY 5/9/\$5 CROWNSVILLE MARYLAND 4 Donation 5 Other (Specify) examiner 21. BIGNATURE OF FUNERAL BETVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. Hilary Stallings 3111 MOUNTAIN_ROAD_PASADENA, MARYLAND 21122 23. PART I. Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feiture. Liet only one cause on each line. filled in by Approximata 5 Intarvai Between IMMEDIATE CAUSE (Final Onset and Death cremation, cute Renal Failue disease or condition resulting in death) signed by the attending physician and completely Health and Mental Hygiene prior to burial, crematic 6041 event, DUE TO (OR AS A CONSEQUENCE OF): Septicenis 10 dy traumatic CERTIFICATION Sequentisily list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING requires that the death certificate be Preunanis CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST Direce 6 PART il. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? GS stor Th ter truet bleeder any 1 TYES 2 NO shows a Carente m leng. 1 YES 2 NO t of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. DR ATTENDING PHYSICIAN: The law g 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h item HOSPITAL: 1 YES 2 NO 1 petient 2 ER/Outputient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, this c 1 Natoral 5 Pending 1 YES 2 NO BY After t Investigation 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, lectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .69 8 Could not be COMPLETED DIRECTOR: 4 Homicide determined 28 ltem. CERTIFYING PHYSICIAN: To the pest of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as etated. (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the sela of examination and/or investigation, in my opinion, death occured at the lime, date and place, and due lo lhe cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c, LICENSE NUMBER 29d, DATE SIGNEO (Month, Day, Year) 4524 5/5 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Glen BURNIE SHARMA 1600 CRAIN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

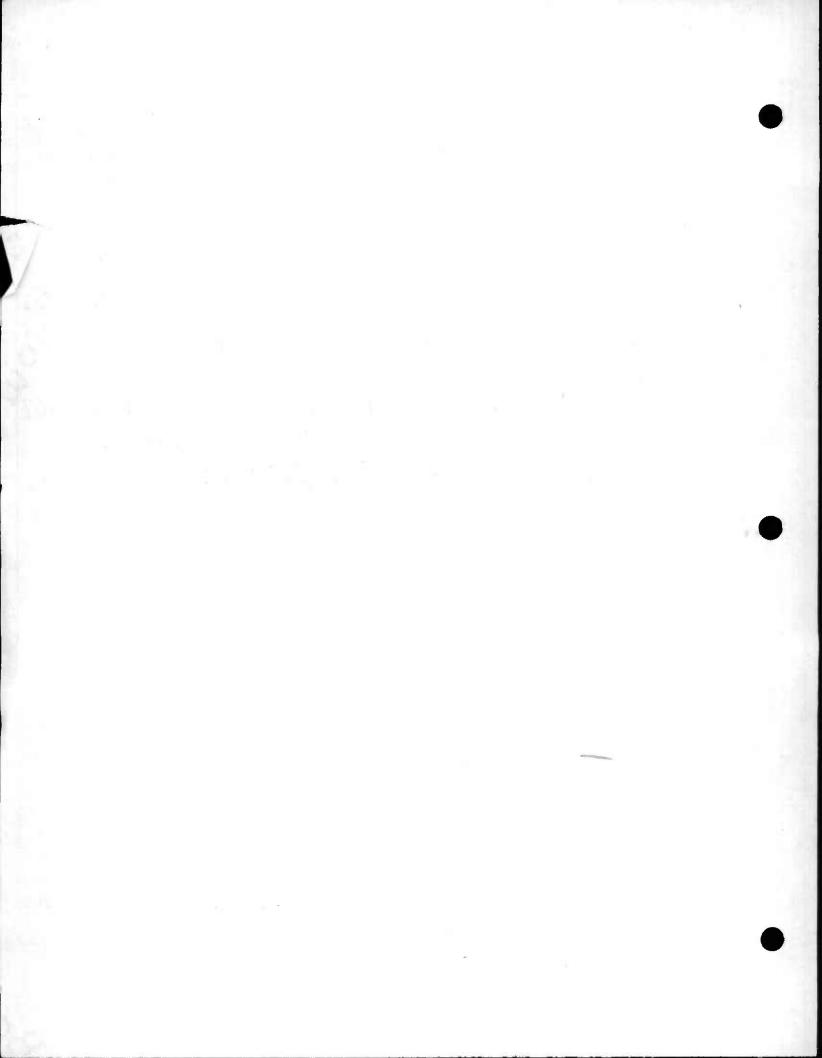
1 - FOR STATE REGISTRAR

y the attending physical Mental Hygiene principle. Injury, or other t	CAL CERTIFIC	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): Contributing to deeth but not resulting in the underlying cause given in Pa							
cian and ci for to buria	RTIFICATION	Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING	t dina	n			yes			
ompletely filted in bill, cremation, or rerevent, the medi		ahock, or heart failure. ListimmEDIATE CAUSE (Finel disease or condition resulting in death)	oue to (or as a c	m Cmi 4		mode of dying, si	uch ss cardiec	or respiratory s	errest,	Approximate interval Batwe Onsat and Dec
d in by the funeral director, page or removal. medical examiner must be		21. SIGNATURE OF FUNERAL SERVICE LICE George E. 23. PART I. Enter the diseases, or co-	MacNabb		Mac 301	Nabb Fur Frederi	neral : ick Rd	. Balt	.o. N	
director, page		20e. METHOO OF DISPOSITION 1 Straight S	al from State Ceme	PLACE AND DATE tery, cremetory or d KE VIEW	of disposition ther place) Memori	al Park	0ATE 5/11/95	20c LOCATION	City or Town	Cánto
pe 5 should	TO E	190. INFORMANT'S NAME (Type/Print) Richard T. Weir	nknecht			et and Number or Run				42
3 & 2	BE CC	17. FATHER'S NAME (First, Middle, Last) Harry	C. Smith			16. MOTHER'S		le, Maiden Surname, Kais	-	
detached for use	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Machine	se retired.)			ufacture	er / Or	ristmas naments
as the	ED BY	1 Never Married 2 Married 3 Wildowed 4 Divorced 15. DECEOENT'S EDUCA (Specify only highest grade or	FORCES? 1 YES IF YES, GIVE WAR OR DAT	16a. DECEDENT'S	1 USUAL OCCUP	YES 2 NO Spe	ican, Puarto Rice	n, etc.)	Specify:	White
pnysician. burial-transit p	FUNERAL	38 Second Avenue	12 MMC DECEDENT FUED IN	U.S. ARMED	13. WAS		.227		US.	
permit. Pages		Maryland 10e, STREET AND NUMBER	Baltimore			Lansdo	wne	1000		LIMITS?
les 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY	71 (41	10c. CIT	Y, TOWN OR LO		OILY			Dd. INSIDE CITY
3 should	R	9a. FACILITY NAME (If not institution, give stre St. Agnes Hosp	· ·		151	on location of	DEATH		N/A	
<u></u>			5. SEX e. AGE (In	yrs. lest birthday) YRS.	MONTHS DA		(Month, D		Country)	ACE (State or Foreign
			KERSHA	W			2. DATE OF WONTH	DAY	95 YEAR	18,50P



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t

		1 - STATE OF MARYLAND / D REGISTRAR STATE OF MARYLAND / D	EPARTMENT OF HI		MENTAL HYGIEN REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last) ERIC	KELLY				3. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last b) $214-82-4415$ 1 \cancel{D} M $_2$ $_{\Box}$ F 3.5		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (Spate or Foreign Country)
2, 3 should	стоя	99. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL RESIDENCE OF DECEMENT	96. CITY, TOWN OF BALTIMO			9c. COUNTY	OFIDEATH
oit. Pages 1,	DIREC	TOTAL SECTION OF THE PROPERTY	Baltim	ore			10d. INSIDE CITY LIMITS? 1 1 YES 2 NO
an. transit permit.	FUNERAL	827 N. Arlington Ave,	i	21217	7	U	OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 V Never Married 2 Merried 3 Widowed 4 Divorced 12. MAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 PNO IF YES, GIVE WAR OR DATES	If yee, spec	ENDENT OF HISPAN city Cuben, Maxica 2 NO Specify	IIC ORIGIN? (Specify Yea n, Puerto Ricen, atc.)	or No- 14	RACE — American Indian, Black, Whita, etc. Specify: Black
or atte	PLETED	(Specify only highest grade completed) (Give	DENT'S USUAL OCCUPATION kind of work done during most o NOT use retired.)		18b. KIND OF BU	SINESS/INDUS	Company
YLAN by the ho	E COMPL	17. FATHER'S NAME (First, Middle, Last) Kirkpatrick Lyles		18 MOTHER'S NA	ME (First, Middle, Maiden	Sumame	Llv
ME, MAR may be retained to pr. page 5 should ast be notified	TO B	Kathleen Parker 137	MAILING ADDRESS (Street and	DAR HURBI	AVE Ba	uto,	Md. 21207
E e e		20e, METHOD DF DISPOSITION 1 1 Suriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	D DATE OF DISPOSITION (Name	TAT D ADDRESS OF FA	5/10/95 BC	alto.	y or Town, Stata
SALT r death. e funeral. exami		23. PART I Enter the diseases, Dr complicatione that caused the deet	Josep 2222	W.Nor	iss Fun Th Ave, I	eral Balto	Home, Md. 21216
d within 24 hours after ompletely filled in by the cremation, or remove event, the medical		shock, or Neert fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition reculting in death) ACUTE ETHANOL, COCA	AINE AND NARCOT			iratory arrest	t, Approximate Interval Between Onset and Death
OX 687(e be executed sician and comprise to burial, traumatic events)	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	ENCE OF):				
h certificat anding phy Hygiene g or other	ERTIFI	CAUSE (Disease or Injury C.	DUE TO (OR AS A CONSEQUENCE OF):				
that the deather the deather the arts the arts and Mental any injury,	AL C	PART II. Other significant conditions contributing to death but not rest	ulting in the underlying	cause given in	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE
REC v requires been sign ft. of Heal	N: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	1 YES NO	UNCERTAIN	1/2 YES 2	NO	OF DEATH?
VITAL AN: The law tificate has e State Oep or Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X YES 2 \(\text{ NO} \) 1 \(\text{ Inpatient } 2 \(\text{ X ER/Outpstient } 3 \)	OF DEATH (Check only one) OTHER: 4 □ Nursing Home	E □ Basidanaa	• El Ottor (Corolla)		
NG PHYSICIA ther this certificath with the marked, or	РНУ	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 1 Netural Pending FOILIND 5 / 05 5	FOUNDRY T 28c. INJURY WOR	RY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED
TOR: A affer do	тер ву	2 Accident a November 1 28e. PLACE OF INJURY — At home.			UNKNOWN 281. LOCATION (Street of City or Town, State) BALTIMORE, M	and Number or 1 2914 RIC ARYLAND	Rural Route Number, DGEWOOD AVE.
7 7 7	COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth one) 2 M MEDICAL EXAMINER: On the best of examination end/or investigation.			to the cause(e) end mer	nner ee atated.	
TO THE HOSPITA TO THE FUNERA DE filed within ??	BE	296. SIGNATURE AND TITLE OF CERTIFIER		O.C.M.			GNED (Month, Day, Year)
2	2	30. NAME AND ADDRESS OF SERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2:					yland 21201
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BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physician.
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he law requires that the death certificate be	e has been signed by the attending physician ie Dept, of Health and Mental Hygiene prior
ICIAN: The law requires that the death certificate be	ertificate has been signed by the attending physician the State Dept. of Health and Mental Hygiene prior
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physics	LTUR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho is the other by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13942 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH DEE KISNICK 7:20 pm May 4 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 X M 2 F 215-03-1439 78 August 4, 1916 Oklahoma 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center Baltimore DIRECTOR Towson, Maryland RESIDENCE OF DECEDENT IRE CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 4801 Walther Avenue 21214 United States 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
if yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried 1 TYES 2 NO Specify: BY Specify 3 Widowed 4 Divorced WW II White COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co. Elementary/Secondary (8-12) College (1-4 or 5+) 9 Chief Clerk Maritime/Longshoreman 17. FATHER'S NAME (First Middle Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) William Kisnick Dicie Connelly BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Dorothy Kisnick 4801 Walther Avenue Baltimore, Md. 21214 20s. METHOD OF DISPOSITION
1 X Burtel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Parkwood Cemetery 4 Donation 5 Other (Specify) 5/8/95 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna 22. NAME AND ADDRESS OF FACILITY Mark Zaropia Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ahock, or heart failure. List only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Final Onaet and Death** disease or condition___ CHRONIC RENAL FAILURE YEARS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): SEPSIS 3 DAYS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CARCINOMA OF THE BLADDER YEARS CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST INSULIN DEPENDENT DIABETES MELLITUS YEARS PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ANEMIA SECONDARY TO A 1 YES NO 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: Inpetient 2 - ER/Outpetient 3 - DOA OTHER 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Netural 5 Pending М 1 YES 2 NO BY Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 4 Homicide 29a. CERTIFIER COMPL

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 MEDICAL EXAMINER: On

ation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and manner as stated.

29¢ LICENSE MUMBER D25888

29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. CEBALLOS M.D. ST JOSEPH MÉDICAL CENTER, TOWSON MARYLAND 21204

34 PEGISTRARY SIGN JUNE

296. SIGNATURE AND TITLE OF CERTIFIER

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DR CEBALLOG MID STILUSERH MEDICAL CENTER TOWSON VARYLAND 21 DGA

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USION OF VITAL RECORDS, P.O. BOX 68760

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	FOR STATE REGISTRAR	STATE OF M.	ARYLAND) / DEPAR	TMENT OF H	IEALTH AND		YGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)			<u> </u>	OAIL OI	DEATH	2. DATE OF C			3 70	ME OF DEATH
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	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E				E (State or Foreign
	212-30-8440	1 🗆 M 2 💢 F	8		MONTHS DAYS	HOURS MIN.	(Month, De	y, Ybar)		Country)	
	9a. FACILITY NAME (If not institution, give :		0	5			March	14,	191Q	Greec	e
l & l						OR LOCATION OF D	EATH		10.000	TY OF DEATH	
DIRECTOR	Franklin Square	Hospital			Rossv	ille			Bal	timore	1
	10a. STATE 10b. COUNT	Υ		10c. CIT	, TOWN OR LOCAL	TION				10d.	INSIDE CITY
1 등 1	Maryland Bal	timore		D.	sedale					1 11	LIMITS? YES 2 X NO
	10e. STREET AND NUMBER	OTIMOT C		1 100		. ZIP CODE			10a CITIZI	EN OF WHAT O	
FUNERAL	5726 Emelia Aven	II.O				21206				ted St	
<u>z</u>	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN II C	ARMED	42 WHE DEC	ENOENT OF HISPA	AUC ODIOING CO.	14 . 54			
	1 Never Married 2 X Married	FORCES? 1	YES 2	X NO	It yes, sp	ecity Cuban, Maxic	nn, Puerto Rican		or No-		merican Indian, la, atc.
E I	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR OATES		1 TYES	2 X NO Specif	ly:		- 1	Specify:	White
	15. DECEDENT'S EQU	CATION	16a.	DECEDENT'S	USUAL OCCUPATION	ON	16b. KIN	O OF BUS	INESS/INOU	STRY	MITTOC
151	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of w life. Do NOT us	vork done during mo e retired.)	isl of working					
12	4	College (I-4 of 5+)		Homema	ker			N/	٨		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			Tromeme	anci	18. MOTHER'S NA	ME (First Middle				
	Nicholas Katso	tic					no Pane				
H	19a. INFORMANT'S NAME (Type/Print)	C13		19b. MAILING	ADDRESS (Street o	and Number or Rural				Podel	
일	Mr. Kimon M. Kou	marianos			Emelia					,	21206
1 1	20a. METHOD OF DISPOSITION	mai ranos	20b PLA		F DISPOSITION (Na		DATE			lty or Town, St	
i I	1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	loval from Stata	comotony	oremeters or of	has alocal	netery	1				
1 1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE Mark	T Zav	KONDS	22. NAME A	ID AOORESS OF FA	CILITY	Dd	TUTINO	re, Ma	ryland
	- maile T	Zawyn		/ Oy IIa		ard J. F		nc.			
	110000				5305	Harford	Road	_Bal	timor	e,Mary	land 21214
1 1	23. PART I. Enter the diseases, or ahock, or heart feilure.	complications that	ceused the	death. Do n	ot anter the mo	da of dying, euc	h as cardiac	or reepli	ratory arre		Approximate Interval Between
	IMMEDIATE CAUSE (Final										Onset and Death
	disease or condition reaulting in death)	. Ischemi	c bowe	e1							3days
11		OUE TO (C	OR AS A CON	SEQUENCE OF	ŋ:						
Z	Sequentially list conditions.	b									
ERTIFICATION	if any, leading to immediate	DUE TO (C	OR AS A CON	SEQUENCE OF	ን፡					[
2	Cause. Enter UNDERLYING CAUSE (Disease or injury	c									
	thet initiated events resulting in death) LAST	DUE TO (C	OR AS A CON	SEOUENCE OF	7):	•					
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LC	PART II. Other eignificent condition	ne contributing to d	leeth but no	ot reaulting i	n the underlying	g cause givan in	Part i. 24a	. WAS AN	AUTOPSY	24b. WERE	AUTOPSY FINDINGS
MEDICAL	Congestive hear					7.65. 56.0		PERFOR	MEO?	AVAIL	ABLE PRIOR TO PLETION OF CAUSE
							t [YES 2	№ мо	OF DE	EATH?
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AN	25. WAS CASE REFERRED TO MEDICAL	1				ACE OF OEATH (C)					
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER:						
¥	1 YES 2 NO	1 Inpetient 2 28a. DATE OF II		26b. TIM		e 5 Residence					
	1 Natural 5 Pending	(Month, Day	r, Year)		URY WO	RK7	28d. DESCRIE	BE HOW IN	NJURY OCCU	JRED	
BY	2 Accident Investigation	280 BLACE OF	IN HIRV	han 4		YES 2 NO					
a	3 Suicide 6 Could not be 4 Homicide determined	building, at	tc. (Specify)	i noma, tarm, a	treat, factory, offic		City or To	wn, State)	nd Number o	r Rural Route N	umber,
ᄪ	20a CENTIFIED				_==						
릴		ICIAN: To the best of m									
COMPL	2 MEDICAL EXAMINI	ER: On the basis of axa	mination and	or investigation	n, in my opinion, d	eath occured at the	time, data and	placa, and	d due to the	cause(s) and	nanner as stated.
w l	296. SIGNATURE AND TITLE OF CERTIFIE					29c, LICENSE NU	MBER		29d. DATE	SIGNED (Mont	h, Day, Year)
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2	30. NAME AND ADDRESS OF PERSON WE						<u>-</u>				
,	Dr. Nimish Gosran				re Dr. B	altimore	Mary1	and	21237		
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BALTIMORE, MARYLAND 21215-0020

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L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be a	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 hours after death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal.	Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be n
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

95 | 3944 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR МАЧТН **JOHN** V. KRAFT 9:02 P.M 95 04 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day Year) 03 29 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-40-3702 DAYS HOURS MARYLAND 51 1 XM 2 - F 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST.AGNES HOSPITAL BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS 2

1 YES Z NO MARYLAND BALTIMORE CATONSVILLE FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 6302 FREDERICK ROAD 21228 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yes, specify Cuban, Mexican, Puerio Rican, atc.)
1 YES NO Specify: . WAS DECEDENT EVER IN U.S. ARMED FORCES? 17 YES 2 \square NO IF YES, GIVE WAR OR DATES VIETNAM11. MARITAL STATUS 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Married В 3 Widowed 4 X Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntery/Secondary (0-12) College (1-4 or 5+) 12 0 PUBLIC SAFETY FIRE-FIGHTER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) VICTOR C. KRAFT SR. ALMA D. DIXON notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CHERYL A. KRAFT 416 HAZLETT AVENUE-BALTIMORE.MD. 21229 Pe 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata wal from State METRO CREMATORY, INC. 4 Donation 5 Donat 5/9 CATONSVILLE, MD. 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD. complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f List only one cause on each line. Intervel Between IMMEDIATE CAUSE (Finel Onsat and Death disease or condition resulting in death) Head niuries DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? 1 YES 2 NO 1 X YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1X YES 2 □ NO 4 Nursing Home 5 Residence 8 Other (Specify) 9 205 O TIME OF INJURY 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED Found 4-95 1 Natural 5 Pending tell down steps M 1 YES 2 NO subject BY 281. LOCATION (Street and Number or Rural Route Nur City or Town, State) / > - -2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, tectory, offica building, stc. (Specify) 3 Suicide 90 COMPLETED 8 Could not be 6302 Frederick 4 Homicide Home Mel 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 💹 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) MAY 5,1995 O.C.M.E. 2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chute M.D.

Dennis J.

31. DATE FILED (Month, Day, Year)
MAY 0 8 1995



111 Penn Street, Baltimore, Maryland 21201

Along & Louise

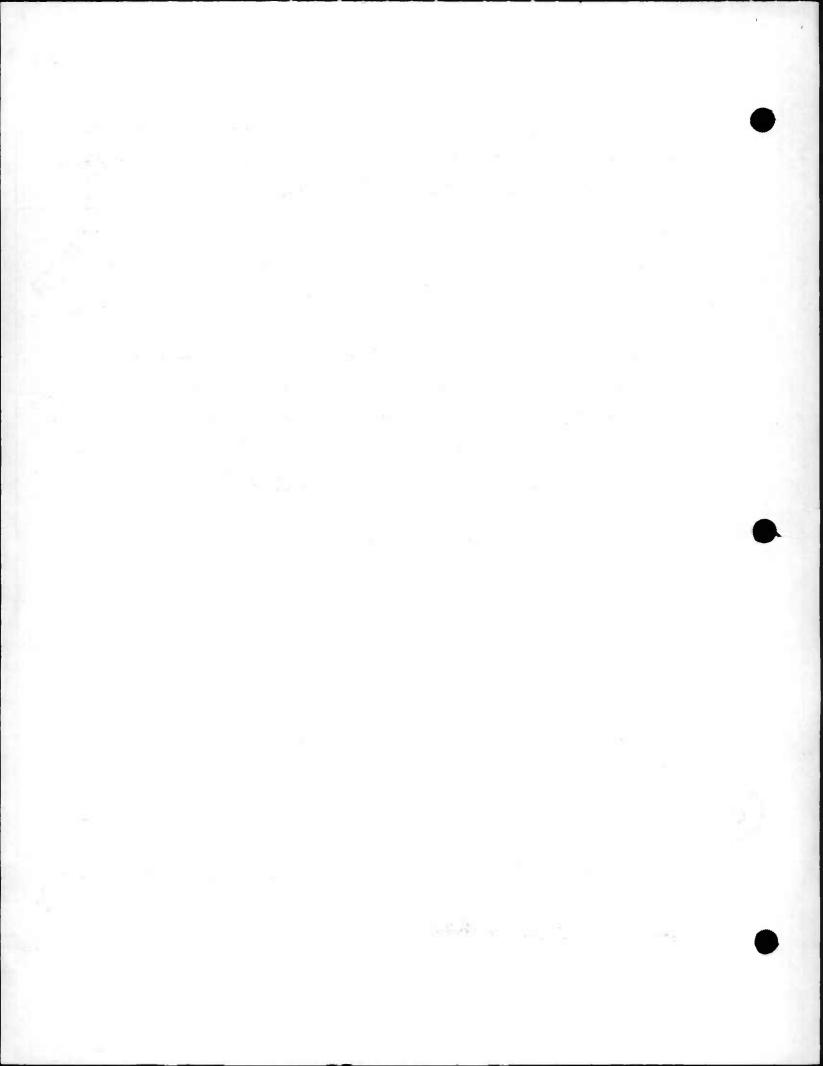
		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMEN CERTIFICAT	T OF H	EALTH AND	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	· · · · · · · · · · · · · · · · · · ·	3.	TIME OF DEATH
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		216 14 1781	1,⊠M 2 □ F 72	YRS. IEST DIRTHORY) IF UNDE	DAYS	HOURS MIN.	7. DATE OF (BIRTH (Month, Die), Year) 7 / 20 / 22	8.	BIRTHPLA Country) Md.	CE (State or Foreign
	ECTOR	9a. FACILITY NAME (If not institution, give stre Howard County Gen			umb:	r location of di ia	EATH	9c, COUNTY	of DEATH	н
		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATE	ON			10,	I. INSIDE CITY
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	FUNERAL		- D.1		101.	ZIP CODE	0.4.0	-10		COUNTRY?
020 physician. burial-tran	S	4027 Sykesvill	12. WAS DECEDENT EVER IN U.	S. ARMED 13.	WAS DECE		.048 NC ORIGIN? (Specify Y		A .	American Indian,
the Find	B⊀	1 Never Married 2 Married 3 Wildowed 4 XXDivorced	FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES	. □ NO	If yea, spe-		n, Puerto Rican, etc.)		Specify V	nite, etc.
r attenduse as	윤	15. DECEDENT'S EDUCA (Specify only highest grade co	TION 16.	a. DECEDENT'S USUAL O (Give kind of work done	during mas	N t of working	18b. KIND OF B	USINESS/INDUS	TRY	
tal or I for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retired.)	damig mod	t or working		Secu	rity	
AND he hospit detached once.	₹ E	High School	=	Prog	ram /	Analyist		al Sec	irity	Admin.
A the be det		17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide	,		
ed a	띪	John Nee 19a. INFORMANT'S NAME (Type/Print)				R	lose Kaylo	r		
BALIIMORE, MARYLAND 2 Ours after death. Page 6 may be retained by the hospital in by the funeral director, page 5 should be detached to or removal. medical examiner must be notified at once.	일	Adrienne Kaylor		19b. MAILING ADDRES			Finkshore Finkshore		_	
		20s. METHOD OF DISPOSITION	205 81	ACEAND DATE OF DISPOS						_
		1 N Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	ol from State cameter	v cremetory or other place				OCATION — City		
Page al dire		21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	rison Fore	NAME AND	ADDRESS OF FA	CILITY	95 Gari	cison	, Ma.
AL IIIN death. Pag tuneral di i. examiner	1 1	* 7/2 M. 41	1 7/2021			_	FuneralH			
S after der by the fur removal.	\vdash	22 PAUT I Fotos the diameter	HUMIN		P.O.1	Box 194	Sykesvill	e, Md.	217	84
ours after of in by the or removements	U	23. PART I. Enter the diameses, or con shock, or heart failure. Lis	at only one cause on each	line.	tha mod	a of dying, auc	h as cardiac or res	piratory arrest	(g	Approximata intarval Batween
ion, if		iMMEDIATE CAUSE (Find disease or condition	P /	. /	0					Onsat and Daath
- 60 CO P	1	resulting in death) a.	Respirat DUETO (OR AS A CO	Ory Con	ur	e				weeks
D 0 10	_		Pheuma							weeks
~ = =	CATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUENCE OF):						WEERS
ate be prior prior	S	CAUSE (Disease or injury								
ertifical ing phy ogiene i	RTIF	that initiated avants reaulting in death) LAST	DUE TO (OR AS A CO	NSEOUENCE OF):						
ath contribution that Hy		d.								
at the deat by the atte and Mental		PART II. Other significant conditions	contributing to death but r	not resulting in the ur	ndarlying	Cause givan in	Part i. 24a. WAS A	N AUTOPSY	24b. WEE	RE AUTOPSY FINDINGS
that the hand by hand hand	MEDICAL		m bolismi			reno	PERFO	PRMED?	AVAI	ILABLE PRIOR TO IPLETION OF CAUSE
requires that been signed . of Health shows an	밀	thrombosid n	narhid of	204%	sep		1 TES	2 0		DEATH?
w req		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YES		UNCERTAIN	<u>-</u>		''	YES 2 NO
ATENDING PHYSICIAN: The law requires that the death certificate ECTOR: After this certificate has been signed by the attending physis a fler death with the State Dept. of Health and Mental Hygiene prince is after death with the State Shows any injury, or other the	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. 1	PLACE OF DEATH (Check	only one)					
IAN: rtifical ne Sta	l Si		OSPITAL: Inpatient 2 - ER/Outpatien	mt 3 DOA 4 Nur		5 - Residence	8 Other (Specify)			
HYSIC Residence of the control of th	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOR	RY AT N/A	28d. DESCRIBE HOW	INJURY OCCUR	ED	
VG PH tter th auth w	BY	Natural 5 Pending Investigation	N/A	N/A"	1 🗌 YE		N/	A		
ENDIII OR: All		3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY — / bullding, etc. (Specify)	At home, farm, street, fact	tory, office		28f. LOCATION (Street City or Town, State	and Number or I	Rural Route	Number,
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETEI			NA				N/A		
로 보인 ==	귤		N: To the best of my knowledge							
TO THE FUNERAL DE filed within 72 I	COMPLE	2 MEDICAL EXAMINER:	On the basis of examination and	d/or investigation, in my o	opinion, dea	ath occured at the	fime, date end place, e	and due to the co	ause(a) and	manner as stated.
A H W THO	BE (200 SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN		29d. DATE SI	GNED (Mor	nth, Day, Year)
N E S	10	YUK MO				D 368	745	Ma	y 5	, 1995
	-	30. NAME AND ADDRESS OF PERSON WHO	EN, MI					_ =	U	
		31. DATE FILED (Month, Day, Year)	ATUXENT 32. REGISTRAR'S SIGNATUR	PKWY #	10	, col	UMBIA	MO	210	244
		MAY 0 8 1995	32. REGISTRAN'S SIGNATUR	r Randall						,

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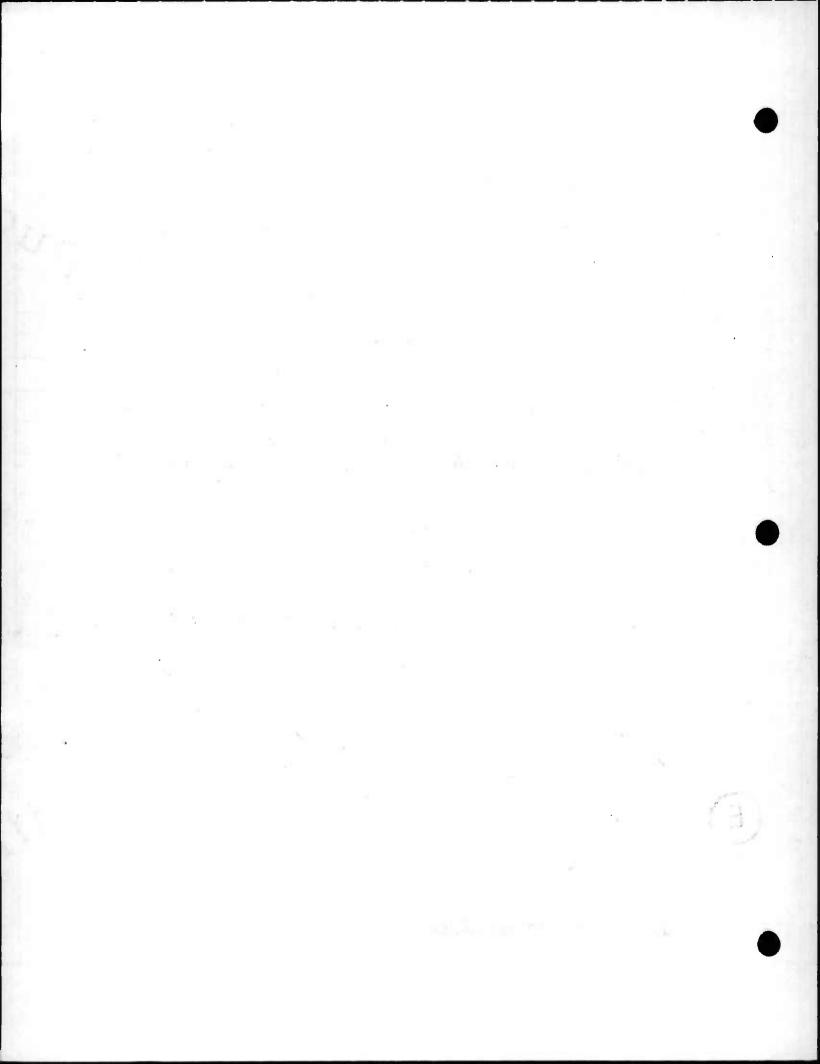
		P	
JOF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within proving after death. Page 6 may be retained by the hospital or attending physician.	r this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should h with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	arked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DRDS, P.O. BOX 68760,	that the death certificate be executed within	r this certificate has been signed by the attending physician and completely filled in by the f h with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	any Injury, or other traumatic event, the
ITAL RECC	The law requires i	cate has been signe tate Dept. of Health	item 23 shows a
OF V	PHYSICIAN	this certific with the S	rked, or I
7		- 5	60

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF I	EALTH AND	MENTAL	HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH		3. TIME OF DEATH
	SUSAN	PARIS LEF	4.2 ic. 17			PD C	iL 29 10	95 YEAR	2:30 Am "
-1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (III	_	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	FBIRTH	6. BIRT	NPLACE (State or Foreign
	27 60 4707	10 H 2) STE H3	YRS.	ONTHS DAYS	HOURS MIN.		28 1953	MA	24 000
	Se. FACILITY NAME (If not institution, give stre	et end number)	9	b. CITY, TOWN	OR LOCATION OF D			COUNTY OF D	DEATH
5	Union Memo	RIAL HOSAT	AL	BALL	more				
NEC ION	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CITY	TOWN OR LOCA	I HON				10d. INSIDE CITY
5	Maskan		Bai	-	42				LIMITS?
- 11	10e. STREET AND NUMBER		Or.	4111	. ZIP CODE		10a.	CITIZEN OF	1 YES 2 □ NO WHAT COUNTRY?
	405 VERIBLE	Avs			21215	3		7.()	٥.
LONERAL		12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN?	(Specify Yee or No	- 14. RAC	E — American Indian,
	1 Never Married 28 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			ocify Cuban, Mexico 200 NO Speci		cen, atc.)	Spec	k, White, etc.
	15. DECEDENT'S EDUCA	T						14	अगिर
	(Specify only highest grade or	ompleted)	(Give kind of wor life. Do NOT use I	k done during mo	ON ist of working	16b. I	(IND OF BUSINESS	INDUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	WAITE	_		R	51.01.00	101	
COMPL	17. FATNER'S NAME (First, Middle, Last)		WHIT	1242	18. MOTNER'S NA	ME (First Mi	ddle, Maiden Surnen	106	
- 11	EUGSOS PARS	4. P ZOO	SR		Bur	7	FAMO	110	
	19e. INFORMANT'S NAME (Type/Print)			DDRESS (Street	nd Number or Rural	Route Numbe		a, Zip Code)	121093
-	SANDRA G. HA	ARS	29 Eps	TRID	GELY RO	190	Limonil	m.r	PRYLAND
	20e, METNOD OF DISPOSITION		PLACE AND DATE OF			DATE	20c. LOCATION	- City or To	
ı	4 Donetion 8 Other (Specify)		Itery, crematory or other		MORIAL	5-2	Timo	aive	MARYLAND
1	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE ()		22. NAME A	S CHAP	CLITY	cHirus		
	Karlo A. CN	A. mas		232	YORK	3000	1	nive	_
	23. PART I. Enter the diseases, pr co shock, pr heart failure. Li	mplications that caused	the death. Do not	enter the mo	de of dying, suc	h aa cardla	C Dr reapiratory	arrest,	Approximate
,	IMMEDIATE CAUSE (Final	at only one cause on ea	ch line.						Interval Between Onset and Death
1	disease or condition reaulting in death)	Cervicot	(ance	~					
1		DUE TO (OR AS A	CONSEQUENCE OF):	-					
5	Sequentially fist conditions, b.	DUE TO 100 10 1		-					
	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						
2	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
-	reaulting in death) LAST								j
5	0.								
ŧ	PART II. Other significant conditions	contributing to death bu	t not resulting in	the underlyin	g cause given in	Part i.	PERFORMED?	24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
5							1 - YES 27 NO	,	COMPLETION OF CAUSE OF DEATH?
						_			1 TES 2 NO
	25. WAS CASE REFERRED TO MEDICAL								
	EXAMINER?	HOSPITAL:		THER:	ACE OF DEATH (C)				
	27. MANNER OF DEATN	1 Inpatient 2 ER/Outpe 28e. DATE OF INJURY	19b. TIME 0	Nursing Non DF 28c, IN.		8 Other	Specify) RIBE NOW INJURY	OCCUPED	
	1 Natural 5 Pending	(Month, Day, Year)	INJUR	Y WO	RK?	200. 0230	NIBE NOW INJUNY	OCCUMED	
	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	- At home, ferm, stre			28f. LOCAT	ION (Street end Nu	mber or Rural	Route Number.
building, etc. (Specify) building, etc. (Specify) building, etc. (Specify) building etc. (Specify)							,		
29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated.									
	(Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) and manner ee stated.								
	296. SIGNATURE AND TITLE OF CERTIFIES	11	4 0		29c. LICENSE NU				(Month, Day, Year)
	Freuel M. (U)	Elen 1	\mathcal{U} . \mathcal{U} .		NZE	979	3	CO CO	(month, bay, rear)
2	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED CAUSE OF DEA	TN (ITEM 27) (Type, Pr	int)	000	115	7	I ITV	1775
	FOUAD M. AI	BBHS, M.	D UM	MS-3	225,	GR	EENE	= 2	1201
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		1 - FOR STATE OF MARYLAND / DEPA CERTIFICATION CERTIFICATI	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.						
		1. DECEDENT'S NAME (First, Middle, Last) Gail Patricia Litfi	.n	2. DATE OF DEATH DAY MAY 06 1	3. TIME OF DEATH 1:47 P M					
P		4. SOCIAL SECURITY NUMBER 213-72-1865 5. SEX 6. AGE (in yrs. lest birthday) 1	# UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC 07, 1957	8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
215-0020 attending physician. se as the burial-transit permit. Pages 1, 2, 3 should	10R	92. FACILITY NAME (if not institution, give street end number) 3537 Greenmount Avenue	9b. CITY, TOWN OR LOCATION OF DE Baltimore	ATH 9c. C	9c. COUNTY OF DEATH N/A					
	DIRECTOR	RESIDENCE OF DECEDENT 106. STATE 106. COUNTY Maryland N/A	TY, TOWN OR LOCATION Baltimor	20	10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
	FUNERAL	100. STREET AND NUMBER 3537 Greemount Avenue	101. ZIP CODE 21218		USA					
	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexicer 1 YES 2 X NO Specify	n, Puerlo Rican, etc.)						
21 21 21 20 21	COMPLETED	(Sipecity only highest grade completed) (Give kind on life. Do NOT li	s usual occupation (work done during most of working use retired.) Adjudicator	Equal Oppor	INDUSTRY					
E, MARYLAND 2 y be retained by the hospital yage 5 should be detached to be notified at once.	101	17. FATHER'S NAME (First, Middle, Last) Jerry S. Litfin	K	ME (First, Middle, Melden Sumame Kathleen A. Wi	lkinson					
	2	Kathleen A. Wilkinson 7208 (G ADDRESS (Street end Number or Rural R Chamberlain Rd. Wo	noute Number, City or Town, State, codlawn, MD 2	Zip Code) 1244					
MORE, age 6 may be director, page		4 Donation 6 Other (Specify)	entiony, Inc. 05/	10/95 Baltimo	- Cify or Town, State One, MD					
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		21. SIGNATURE OPPONERAL SERVICE LICENSEE MacNabb Against And Address of Facult Home, P.A. George E. MacNabb 301 Frederick Rd. Baltimore, MD 21228								
filled in by on, or remo		23. PART i. Enter the diseases, or complications that caused the deeth. Do shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)		n ea cerdiec or reapiratory	Approximate interval Between Onset and Death					
687 ecuted ind con burial,		Sequentially list conditions,	45 WAR ATTH	evol (Tekol)						
ficate be physician ne prior t		cause. Enter UNDERLYING CAUSE (Disease Dr injury Due TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUEN	N01211	`^~						
Ten at P		PART II. Other significent conditions contributing to deeth but not resulting	E MENAL DI		UNKNOWN					
द हित्र हा	MEDIC	DIAGETE MELLITU.	1	PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
TAL I	¥	EXAMINER? HOSPITAL:	ATH (Check only one)							
OF V PHYSICIAL this certifi with the	PHYS	1	4 □ Nursing Home 5 M Residence (ME OF JURY 26c. INJURY AT WORK?	6 Other (Specify) 26d. DESCRIBE HOW INJURY O	OCCURED					
DIVISION OF VENDING F		2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, building, etc. (Specify)	M 1 YES 2 NO	281. LOCATION (Street and Num. City or Town, State)	ber or Rural Route Number,					
NO THE	MPCE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occur one) 2 MEDICAL EXAMINER: On the best of examination end/or investigate								
TO THE HOST TO THE FLIE The filed with	O BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER +	29c. LICENSE NUM	BER 29d. D	ATE SIGNED (Month, Day, Year) [Ay 08, 1995]					
10	10	Jo. NAME AND ADDRESS OF PERSON WHO COMPLETED CAME DEATH (ITEM 27) (Non-Luis Gimenez, M.D. 5601 Loch Raven	Blvd. Baltimore,		239					
		MAY 0 8 1995 July Days Control of the Control of th								



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Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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30. NAME AND ADDRESS OF PERSON

SURYA

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Arint)

203 E

95 13948 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 May 03 Margaret J. Legge 4:40 Α. 4. SOCIAL SECURITY NUMBER S SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 🗌 M 2 🖎 F 016 22 3803 96 June 19, 1898 Scotland 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Knollwood Manor Nursing Home DIRECTOR Millersville Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland Anne Arundel Millersville 1 - YES 2 1 NO FUNERAL 10e, STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 899 Cecil Avenue 21108 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married 1 YES 2 X NO Specify: Specify: BY 3 Wildowed 4 Divorced White 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) 8th Home Maker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Grigor Jobina Cameron 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Donald C. Legge 1131 Severnview Drive Crownsville, Maryland 21032 20a METHOD OF DISPOSITION

1 Burlai 2 Cremation 3 Ram

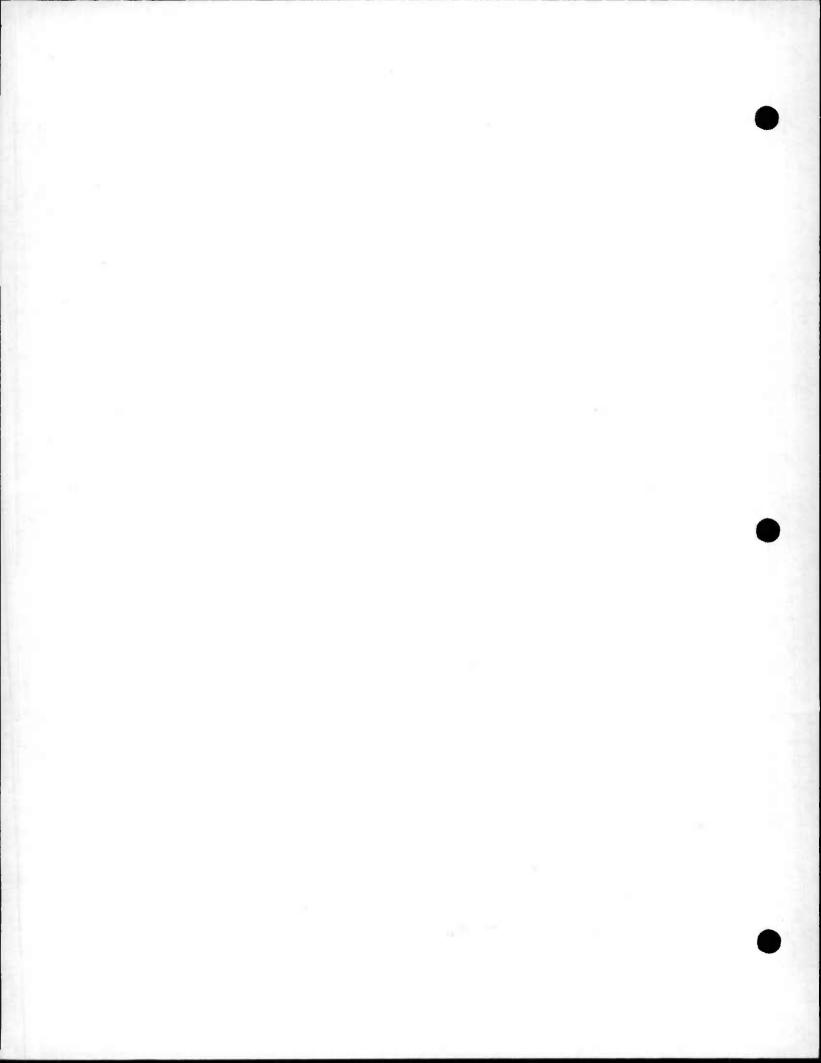
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Cedar Grove Cemetery

Cedar Grove Cemetery 5/6 Boston, Massachusetts 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART I. Enter tha diseasea, or comply ations that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory errest, shock, or heart fellure List only one ceuse on sech line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) SERSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF)if any, leading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY MALNUTRITION PERFORMED? 1 TYES 2 WHO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only goe) HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 WO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Matural 5 Pending BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year)

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		1 - FOR STATE REGISTRAR	TATE OF MARYL		RTMENT OF I		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Lest) BONNIE JEAN LEWI	S				2. DATE OF DEATH DO S	AY YEA 9.5	
pino			M 2 X F 59	In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC. 23, 193	35 W	RTHPLACE (State or Foreign suntry) VIRGINIA
2, 3 should	TOR	99. FACILITY NAME (If not institution, give street an 330 STEMMERS RUN ROA			A CONTRACTOR OF THE CONTRACTOR	OR LOCATION OF DE	(ESSEX)	9c. COUNTY O	F DEATH LTIMORE
t. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY	TIMORE	10c. CIT	TY, TOWN OR LOCA	SEX			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
n. Insit permit.	FUNERAL	100. STREET AND NUMBER 330 STEMMERS RUN ROA	AD	,	16	21221			F WHAT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	ΒY	1 Never Married 2 Merried	MS DECEDENT EVER IN ORCES? 1 YES YES, GIVE WAR OR DA	2 NO	If yes, s	CENDENT OF NISPAI pecify Cuben, Mexica \$ 2 X NO Specif	NIC ORIGIN? (Specify Yes in, Puerto Ricen, etc.)		ACE — American Indien, llack, White, stc. pecity: WHITE
212	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Colle 1 OTH GRADE	oge (1-4 or 5+)	(Give kind of life. Do NOT us	USUAL OCCUPATI work done during m se retired.)	ost of working	166, KIND OF BUS	SINESS/INDUSTR	
YLAND 2 by the hospital i be detached to at once.	BE COM	17. FATHER'S NAME (First, Middle, Last) WILLIAM E. KEEFOVER					ME (First, Middle, Melden BEATRICE GI		
ORE, MARY 6 may be retained I ator, page 5 should nust be notified	TO B	190. INFORMANT'S NAME (Type/Print) MR. DENNIS W. DENNIS					Poute Number, City or Tow ENUE - BAI		
		29e. METHOD OF DISPOSITION TO Buriel 2 Cremetion 3 Removal fro 4 Donation 5 Other (Specify)	om State cem B	PLACE AND DATE (latery, crematory or of EVERLY H	OF DISPOSITION (N ther place) ILLS MEN	lame of M.GARDENS		COVER, V	
BALTIMOR after death. Page 6 ma by the funeral director, invoval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Shann	on	HUBBAI		CILITY L HOME, IN VENUE - BA		E, MD 21229
within 24 hours aft within 24 hours aft pletely filled in by cremation, or remo		23. PART Lenter the diseases, or compliance, or heart feliure. List or IMMEDIATE CAUSE (Finel disease or condition resulting in death)	nly one cause on as	sch line.	not antar the mo	oda of dying, auc		ratory srrest,	Approximate interval Between Onset and Desth
P.O. BOX 68 h certificate be executionally physician and c Hygiene prior to burist or other traumatic	CERTIFICATION	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	ple (ressel	CORDNAR	y dise	Ase 5 yps
NEDS, P hat the death 1 by the atter and Mental ny injury, o	<u> </u>	PART II. Other algorificant conditions cont PREVIOUS MYDEAR	tributing to deeth be	ut not resulting	In the underlyin	ng cause given in	PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
IL RECO	N: MEDICA	DID TOBACCO USE CONTRIBUT	1/ar Fur	CTION	DIADES NO	UNCERTAN	pel	ANO	OF DEATN? 1 YES 2 NO
TA The ate h ate D	rsician:		SPITAL: npatient 2 - ER/Output	26. PLACE OF DEAT	OTHER:	ne 5 Residence	6 Other (Specify)		
PHYSIC this ce with the	ву Рну	Netural 5 Pending 2 Accident investigation	(Month, Day, Yeer)		M 1-	JURY AT ORK? YES 2 NO	28d. DESCRIBE NOW II	NJURY OCCURED	
TVISION TENDING TEN R: After Ter death Tri fs mai	ETED	4 Homicide determined	28e. PLACE OF INJURY building, stc. (Speci	my)			28f. LOCATION (Street a City or Town, State)	-	al Route Number,
	COMPL	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the							ie(e) end menner ee stated.
TO THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF THE FIND OF T	TO BE	286 SIGNATURE AND TITLE OF CERTIFIER A 7 30. NAME AND ADDRESS OF PERSON WHO COME	TENDING			DIG 2	IBER OO	≥ 5	S-95
15		DR. NORBERTO M. MACI		20 MAIDE		E LANE -	CATONSVILL	E, MD 2	1228
		MAY 0 8 1995 July		-					
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BALTIMORE, MARYLAND 21215-0020	DING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
ION OF VITAL RECORDS, P.O. BOX 68760	DING PHYSICIAN: The law requires that the death certificate be executed with	After this certificate has been signed by the attending physician and completely fi

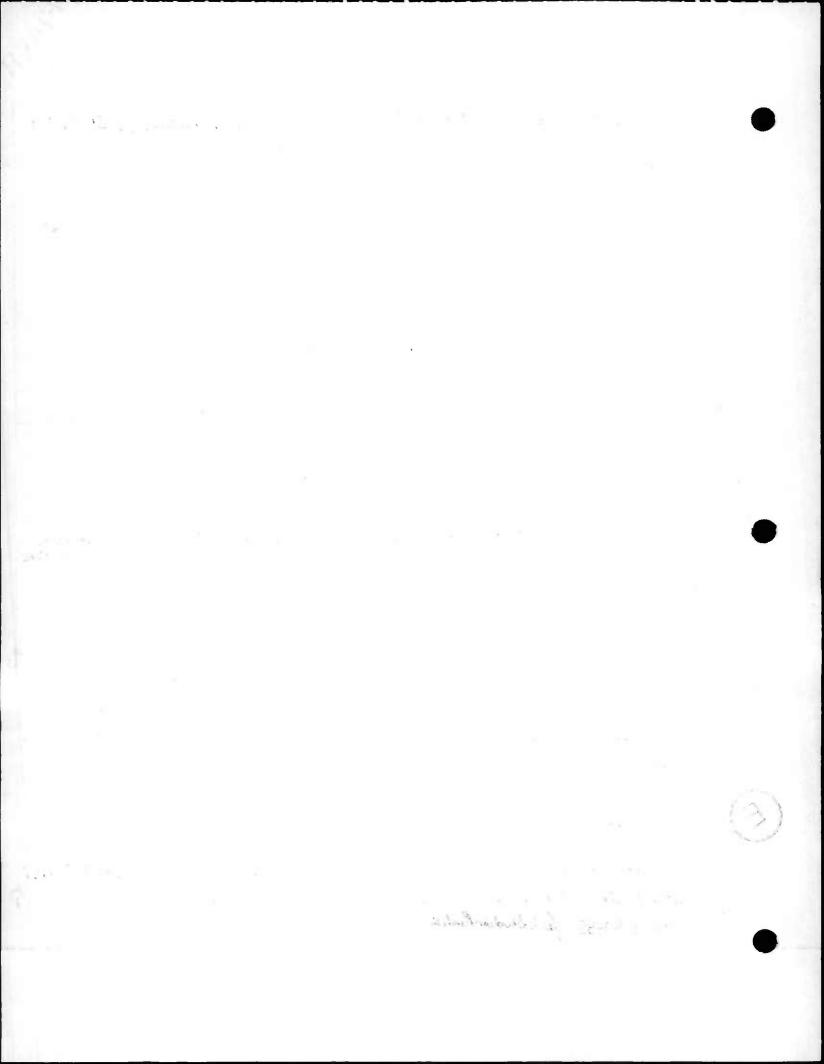
TO THE HOSE IN CONTRIBUTION OF PRINCIPAL THE Law requires that the death certificate be executed with the flow of the funeral director, page 5 should be detached filed within the contribution of the flow within the contribution of the flow within the state Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

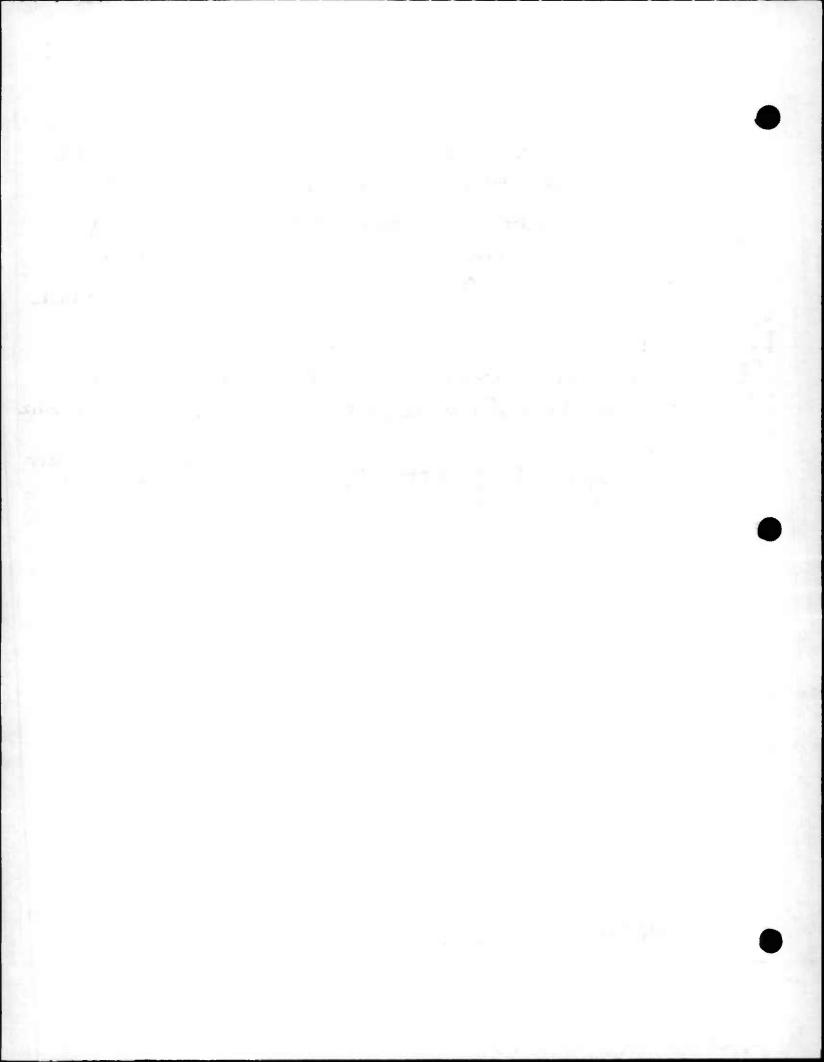
	REGISTRAR				CERTIF	ICALE	: Or	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) FORN M LOFF					T				2. DATE OF DEATH MONTH MONTH MAY FIFTH 19 95 SEVEN PM				
- 2	4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In vrs.		s. last birthday)	IF UNDER	F UNDER 1 YEAR		7. DATE OF BIRTH				IPLACE (State or Foreign	
	129-32-3371		1 🗆 M 2 🔀 F	55	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, C	lay, Year)	940	Counti	York	
	9e. FACILITY NAME (If not institution, give street end number)					9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH			
DIRECTOR	Howard County General Hospital					Columbia Howard						oward		
۳ ا	10e. STATE 10b. COUNTY 10						Be. CITY, TOWN OR LOCATION 18d. INSIDE CITY							
ā	Maryland Howard				E1	Ellicott City				,			1 YES 2 NO	
٦I	10e. STREET AND NUMBER					10f. ZIP CODE					10g. CI	IZEN OF V	WHAT COUNTRY?	
띮	3106 N. Chatham Road					21042					Ţ	JSA		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 X							PANIC ORIGIN? (Specify Yee or No-			14. RACE	E — Americen Indien, k, White, etc.		
B	1 Never Merried 2 Married 3 Widowed 4 Divorced PORCES 1 YES 2 MA IF YES, GIVE WAR OR DATES					1 ☐ YES 2 NO Specify:					Specify: Wh			
요	15. DECEDENT'S EDUCATION 18e. DE (Specify only highest grade completed) (G					ECEDENT'S USUAL OCCUPATION			16b. KIND OF BUSINESS/INDUSTRY					
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)			.)	111111111111111111111111111111111111111			ork done during most of working retired.)		Howard County		ntv		
<u> </u>			2+		Diet	Techi	echnician		General Hosp				-	
ខ្ល	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S				IAME (First, Middle, Maiden Surname)				
H H	Harry Francis Heckmann					Mildred Barbara Meidenbauer						er		
2						MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)								
-	Patrick M. I				3106	N. C	nath	am Rd. E	llico	ott City, Md. 21042				
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 M Cremetion	3 🗆 Remo	oval from State	cemetery	, crematory or o	EAND DATE OF DISPOSITION (Name of						- City or To	wn, State	
		Balt-Wash Crematory Inc 5-7-95 Laurel, Md.												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY C1 of Funeral License D 3													
	Slack Funeral Home, P.A. Ellicott City, Md. 21043													
	23. PART I. Enter the dise	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate												
	ahock, or heart failure. List only Dna cause Dn each lina. IMMEDIATE CAUSE (Final Onset and Daath													
- }												THREE		
	disease or condition											MONTHS		
z	Commentation that are a first	MONT												
	If any, leading to immedia	Sequentially list conditions, If any, laading to immediata DUE TO (OR AS A CONSEQUENCE OF):												
ERTIFICATION	cause, Entar UNDERLYING CAUSE (Disease or Injury													
	that initiated avents resulting in death) LAST	that initiated avents DUE TO (OR AS A CONSEQUENCE OF):												
			l											
	PART II. Other algolificant	condition	contributing to	death but no	ot reaulting	in tha un	darlyln	g causa givan in	Part I. 24	e. WAS AN		24b.	. WERE AUTOPSY FINDINGS	
DICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ш										1 TYES 2 NO			OF DEATH?	
2										I A				
PHYSICIAN:	25. WAS CASE REFERRED TO M	-			LACE OF DEA								7.0	
2	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3					OTHER:				S Other (Specify)				
Ē	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)					E OF URY	28c. INJ	URY AT	28d. DEŞCRIBE HOW INJURY OCCURED					
2	1 Netural 5 Pending 2 Accident Investigation				1145	M	WORK? M 1 YES 2 NO							
	3 Suicide S Could not be building, etc. (Specify)					ome, ferm, street, fectory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
<u>"</u>	4 Homicide det	ermined	12.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					City Or 1	OWII, State)				
ž 1	29a. CERTIFIER (Check only	ING PHYSIC	DAN: To the best of	my knowledge	, death occum	d at the ti	me, date	end piece, and due	to the cause	e) end men	ner se sta	rted.		
COMPLEIED) end manner ee stated,	
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE								
出	OBsila: zlu- mi)					2			D 4113 9			≥ MAY, SEVEN (1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												.,	, (11)	
	11065 Mitt	1065 hit & Petuxet Parkway Columbia W.D.												
	31. DATE FILED (Mapth, Pay No.	Jal	A PERSONAL	B CHANNE	E									



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1
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FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SHERMAN 7. DATE OF BIRTH 6. AGE (In yrs. lest birthday (Month, Dely, Year) 2-78-559 5 1959 Pages 1, 2, 3 should 9e. FACILITY NAME (If not instit TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JOSEPH TIMORE RESIDENCE OF DECEDEN 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY Ma 10d. INSIDE CITY BALTIMORE 1 YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10a CITIZEN OF WHAT COUNTRY? RING ANE 21212 USA Jeath. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Ind Black, White, atc. If yes, specify Cube 1 YES 2 NO 2 Married Black BY Specify: Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY lege (1-4 or 5 +) ONashore MAN 18. MOTHER'S NAME (First notified at BE 2 21515 pe METHOD OF DISPOSITION 20a METHOD OF DISPOSITION
1 Removal from State 20h PLACE AND DATE OF DISPOSITION (Nam must ☐ Donation 5 ☐ Other (Specify) examiner OF FUNERAL SERVICE LICENSEEA 22. NAME AND ADDRESS OF FACILITY 1215 6 filled in by the fillion, or removal. 00 TO THE HUNERAL DIRECTOR: After this certificate has been signed by the FUNERAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dent. of Health and Mental Hygiene prior to burner, the medical IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Finel **Onset and Death** diseese or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Kespiratory Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING amentra CAUSE (Disease or injury thet initieted eventa resulting in deeth) LAST LMMUNE PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 I ER/Outpatient ng Home 5 🗆 Residence 6 Other (Specify) OSP 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 29e. CERTIFIER (Check only one) e, date end place, end due to the ceuse(s) end menner es stated. 296. SIGHATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) (oles) 5-COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO C MID 828 N. Garaw S 14 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-002	mount offer doubt. Dans & man by make he she had been been and the she
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O. BOX 68760	that the death cartificate be executed with
JF VITAL RECORDS, P.O. BOX 68760	somiron that the dank
USION OF VITAL	A ATTENDED BHYSICIAN: The law
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TO THE HOSPITA
TO THE FUNERA
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IMPORTANT:

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2 MEDICAL EXAMINER: On the

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Juli Hiller Berkelle

FURE AND TITLE OF CERTIFIER

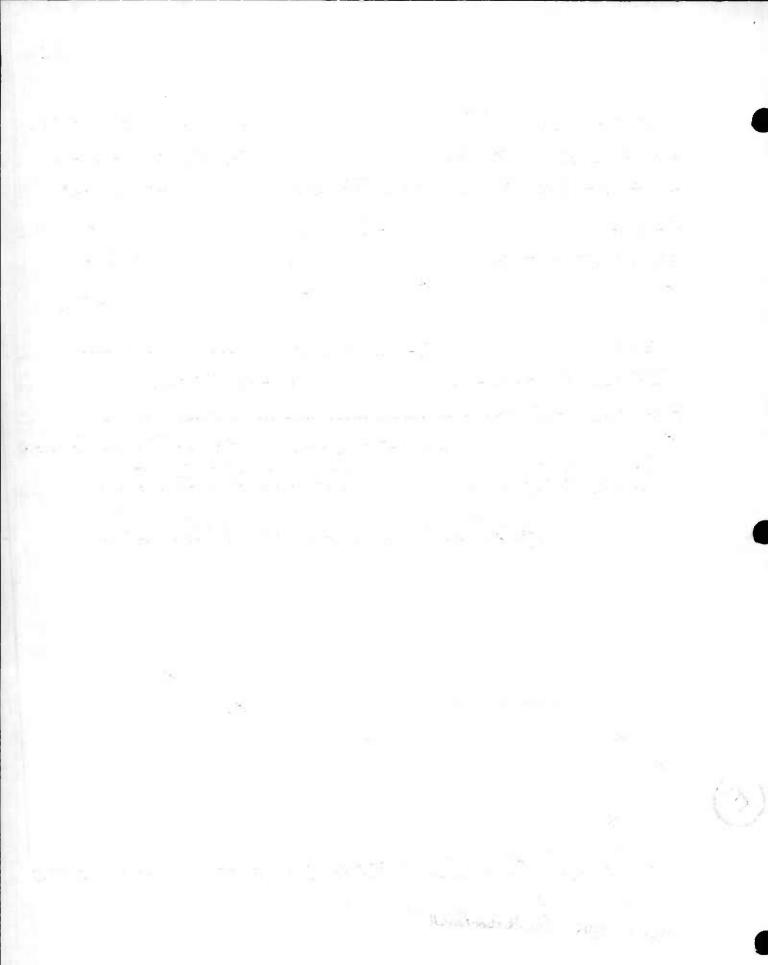
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95 13952 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH :40P.M ATHI FARLAND APR:1 27 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a, BIRTHPLACE (State or Foreign थाय रह 1 M 250 9a. FACILITY NAME (If not institution, giv 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORS PESIDENCE OF DECEDENT DIRECTOR lursing Home 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PRYLAND mores 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21212 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) RACE — American Indian, Black, White, atc. If yes, specify Cuba 126 Never Married 2 Married BY Specify 3 Widowed 4 Divorced BE COMPLETED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) RS DEPARTMENT R notified at once. 17. FATHER'S NAME (First, Middle, Last) 16, MOTHER'S NAME (First 63 UMAL 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, 2 PRYLAND be 20a. METHOD OF DISPOSITION
1 ★Burlel 2 ☐ Cremation 3 ☐ Ran 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must څ imore! ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY OF Nam Yo 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition 105claroke resulting in death) DUE TO (OR AS A CONSEQUENCE OF) BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 0 PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 25 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [NO 🔀 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER Nursi 1 YES ZE NO 1 Inpetient 2 I ER/Outpetient 3 II DOA 8 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 K CERTIFYING PHYSICIAN: To the best of

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burjal-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

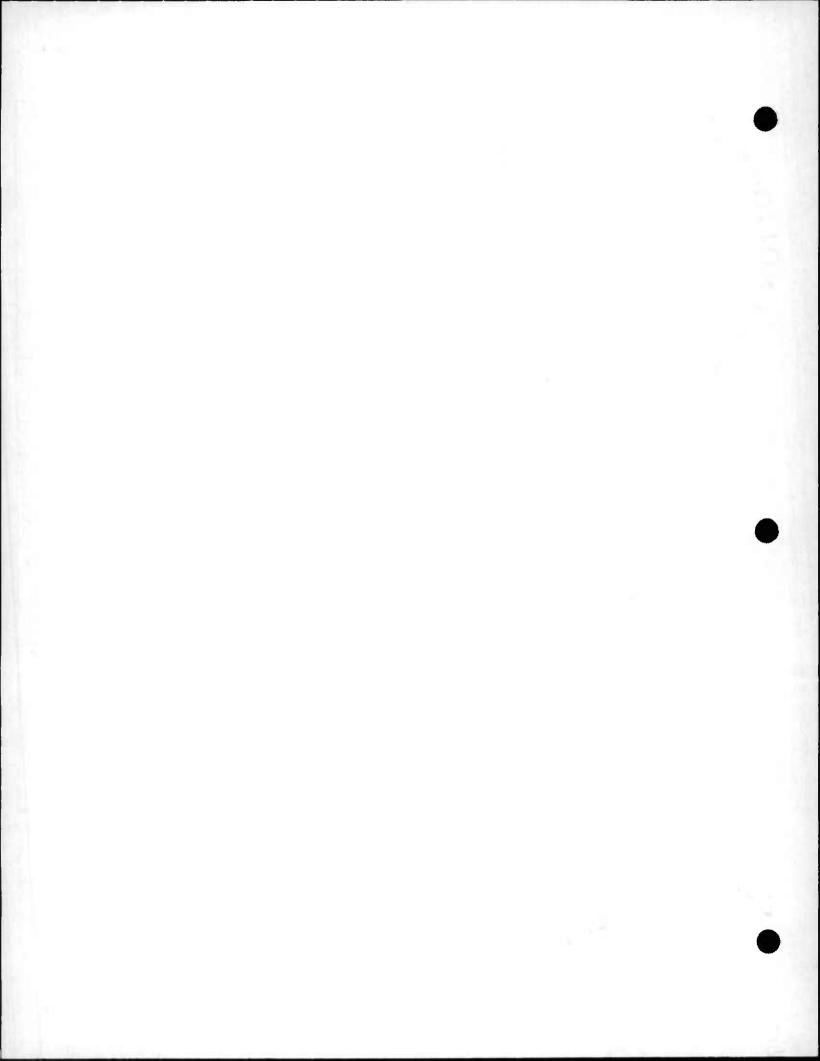
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1 - FOR STATE REGISTRAR		STATE OF MA				F HEALTH AND OF DEATH		YGIEN	E		
1. DECEDENT'S NAME (First,	Middle, Last)					, BEATH	2. DATE OF		5/7/99	5	3. TIME OF DEATH
Harken	HORKERS - FONA THE Edna M					on	MONTH	DA		YEAR	
4. SOCIAL SECURITY NUMB	ER	5. SEX 6.	AGE (In yrs. las		F UNDER 1 YE		7. DATE OIL		"	95	8-50A M
235-14-2		1 - M 2 - F	84	YRS.	ONTHS DA	YS HOURS MIN.	(Month, Di	sirih sy, Year)		Counti	PLACE (State or Foreign by) t Virginia
9a. FACILITY NAME (If not ins			•	9		VN OR LOCATION OF C	EATH		9c. COU	NTY OF D	EATH
Harbor H	_	1 Center			Balt	imore			N.A	A.	
RESIDENCE OF DEC	10b. COUNTY			Sec.							
1					TOWN OR LO	CATION					10d. INSIDE CITY LIMITS?
Maryland	Bal	timore		Ark	utus						t TYES 2 X NO
100. STREET AND NUMBER 921 915 Maide	n Choi	go Tama				10f. ZIP CODE					WHAT COUNTRY?
	n Choi					21229				J.S.A	A.
11. MARITAL STATUS 1 Never Married 2 1	Mandad	12. WAS DECEDENT E FORCES? 1			13. WAS	DECENDENT OF HISPA , specify Cuban, Mexic	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	E — American Indian, k, White, atc.
3 🖫 Widowed 4 🗆 Divor		IF YES, GIVE WAR				YES 2 X NO Spec		ii, araij		Speci	Hy:
-			-		1						White
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12th			H	ome Ma	ker			wn He			
17. FATHER'S NAME (First, Mic		arry May	ola			18. MOTHER'S N. E1	ME (First, Middi 1en Ja:		,	5	
19a. INFORMANT'S NAME (Ty	rpe/Print)		19	b. MAILING AD	ODRESS (Str	eet and Number or Rural	Route Number, (City or Town	, State, Zip	Code)	
Ken Irela	nd			500 Pe	nny I	ane	Cockey	svi1	le. N	Marv1	land 21030
20a. METHOD OF DISPOSITIO				AND DATE OF			DATE	_		City or To	
t KBurial 2 Cremation 4 Donation 5 Other		vel from State	cemetery, cre	matory or other	place) Memo	rial Park	5/10	G14	an Ri	mi	e, Maryland
21. SIGNATURE OF FUNERAL		ENSEE	020	1		E AND ADDRESS OF F		01	-11 D	ALIII	e, Maryrand
1 / /a	-21	7		//.	Geo	rge J. Goi	ice Fun	eral	Hom	e P.	A.
John	a 16	George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225									
23 PADT I Enter the diseases of supplications that accord the death December 1						1 Ritchie	Hwy.	Ba1t	imor	e, M	d. 21225
23. PART I. Entar the dis	seases, or s	purplications that co	used the de	eath. Do not	400 entar tha	1 Ritchie	Hwy .	Balt or respin	imor	e, M	
snock, or ha	art fellung L	amplications that co	used the de	eath. Do not	400 entar tha	Ritchie moda of dying, suc	Hwy .	Balt or respin	imor	e, M	Approximata Interval Between
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Sequentially list condition resulting in death) Sequentially list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or Injur	ona, Itata	DUE TO (OR	AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF	DUENCE OF): QUENCE OF): CITUM	entar tha	mode of dying, suc	m a	or respi	imor etory an	e, M	Approximata Interval Between Onset and Death
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E V PR ZI D C CONTROL

nours after death. Page 6 may be retained by the hospital or attending physician.	d in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 or removal.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or attending physicians and the property of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

31. DATE FILED (MONTH, Day, Year) МДҮ 0 8 1995

	FOR STATE	STATE OF MARY	LAND / DEPART	MENT OF H	EALTH AND			, , , , , , , , , , , , , , , , , , , ,
	1. DECEMBRIT'S NAME (First, Middle, Last)	1 E. 1	MAY	CATE OF	DEATH	2. DATE OF I	DEATH DAY	9 GEAR 3. TIME OF DEATH
	4. social security number 217 01 5082	1 🔀 M 2 🗆 F	-	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, Da	nr. Yhari	6. BIRTHPLACE (State or Foreign Country) 8 Maryland
TOR	9a. FACILITY NAME (If not ingitiation, give s	Lei Hosp	oital	96. CITY, TOWN O	PRIOCATION OF D	NIE		me Arunder
DIRECTOR	10a. STATE 10b. COUNT	ne Arundel		TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	8585 Bay Road			101	21122		10g.	CITIZEN OF WHAT COUNTRY?
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	If yea, sp	ENDENT OF HISPA ecity Cuban, Mexic 2 NO Speci	an, Puerto Ricar	pecify Yes or No- n, atc.)	14. RACE — American Indian, Black, White, atc. Specify: White
TED	15. DECEDENT'S EOU (Specify only highest grade	ICATION completed)	16a. OECEDENT'S U	SUAL OCCUPATION done during mo retired.)	ON st of working	16b. KIN	D OF BUSINESS	
COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		nginee			Chemic	al Plant
6 LUI	17. FATHER'S NAME (First, Middle, Last)	George Alber	t May		18. MOTHER'S NA	AME (First, Middl edrica	e, Maiden Surnam Sacks	oe)
TO BI	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A		nd Number or Rural	Route Number, C	City or Town, State	
5	Joyce Martinek	20	b. PLACE AND DATE OF	ergreen	me of	CATE		land 21144
	1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	Î	metery, crematory prothing deadowride	je Memor	ial Par	5/5	Baltin	more, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	Hon	ce		e J. Gon Ritchie			me P.A. re, Md. 21225
	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. ATNIA	- AB	PERCATO			or reapiratory	Interval Between Onset and Daath
PTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	DUE TO GOR AS	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	HELL	175	VR E	-	1 year
Ö	resulting in death) LAST	a EMPITE	sent		CAR(IN		of Lu	NG BYEARS
MEDICAL	PART II. Other significant condition	s contributing to deeth	but not resulting in	the underlying	ceuse given in		WAS AN AUTOP PERFORMED? YES 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN: N	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH YES	NO D	UNCERTAI	N 🗆		1 🗆 YES 2 🕽 410
Sic.	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	HOSPITAL:		OTHER:	S - Bestdese	4 C On (G-		
ВУ РНҮ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	OF 28c. INJ	URY AT RK?		BE HOW INJURY	OCCURED
8	3 Suicide 6 Could not be determined	28a. PLACE OF INJUR building, atc. (Spe	Y — At home, ferm, atricity)	eet, factory, office		26f. LOCATION City or Tox	N (Street and Num wn, State)	nber or Rural Route Number,
티		CIAN: To the best of my know						stated. o the cause(a) and menner as stated.
O BE COM	29b. SIGNATURE AND TITLE OF CERTIFIES	brechfele	ny		29c. LICENSE NUI	WBER 221	29d. C	Mary 2, 1998
F	36 NAME AND ADORESS OF PERSON WH	O COMPLETED CAUSE OF OR		rine) 1 1-to()	PITAL V	Ause	60	en BurniE,

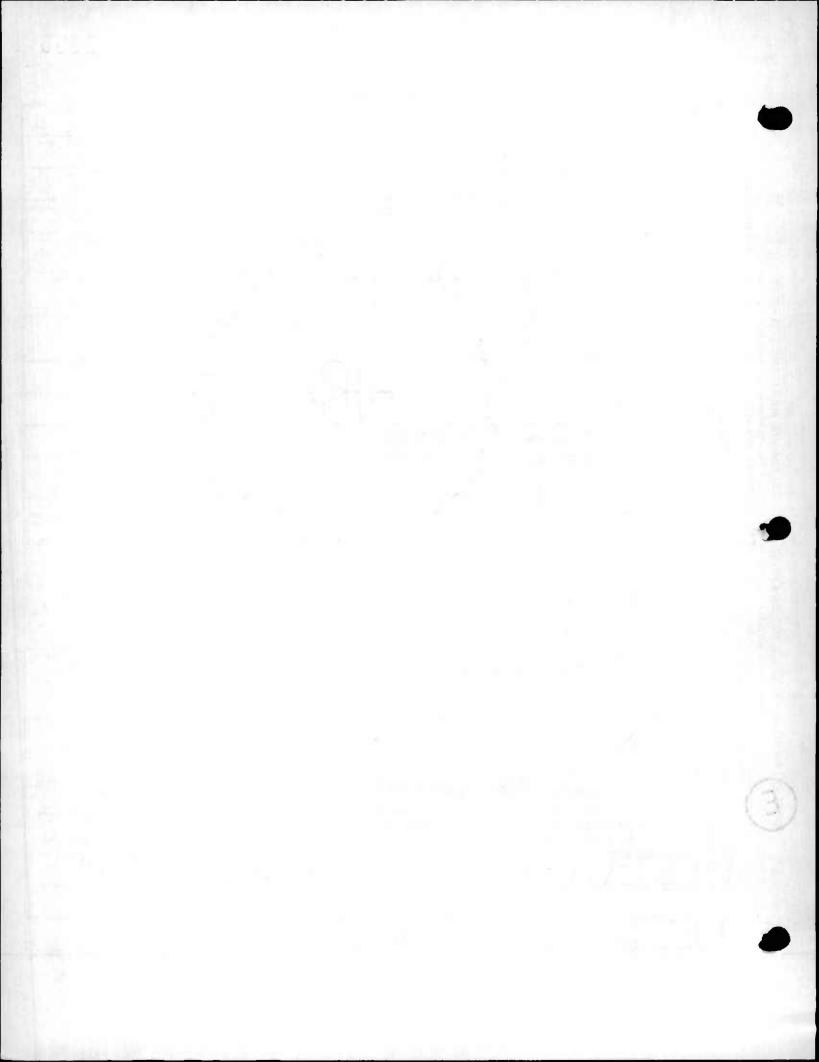


		1 - STATE REGISTRAR	STATE UF MA			ICATE OF		MENTAL	REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)	Verna Pa	uline N	lalo:	zi		2. DATE OF MONTH	5 DEATH DA		VEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER				F UNDER 1 YEAR			7. DATE OF BIRTH 8. F		8. BIRTHPL	ACE (State or Foreign
목		211-12-1992		77	YRS.	3123	HOURS MIN.	Dec.				ylvania
2, 3 should	DIRECTOR	98. FACILITY NAME (If not institution, give street and number) 96. COUNTY OF DEATH Franklin Square Hospital Rossville Residence of decedent										
Jes 1,	낊	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOCA	TION				10	d, INSIDE CITY
permit. Pages		Maryland	Baltimore	e		17E	ssex					LIMITS? ☐ YES 2 NO
sit	FUNERAL	14 Judywood Lane				10	1. ZIP CODE	221			ited S	States
21215-0020 all or attending physician. for use as the bunal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 X NO		If yes, sp	CENDENT OF HISPA Healty Cuban, Mexic S 2X 3-NO Spec	cen, Puerto Ric		or No	14. RACE — Black, W Specify:	American Indian, Thita, atc. White
21215-0 al or attending for use as the	G	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DEC	EDENT'S	USUAL OCCUPATI	ON	16b. K	UND OF BUS	INESS/IND	DUSTRY	write
21 for u	COMPLETED	Elementary/Secondary (0-12) 9 Years	College (1-4 or 5+)			work done during mose retired.) Wife	ost of working		Own t	lome		
AND the hospit detached once.	Į į	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N					
RYL ad by a	BE (Horace King						vrie Av				
MAR retained 5 should notified	2	19a. INFORMANT'S NAME (Type/Print)				ADDRESS (Street of						
ORE, I 6 may be ctor, page t		Patric T. Jones 299. METHOD OF DISPOSITION		20b. PLACE AL	ND DATE O	White of DISPOSITION (N.	ame at	DATE	200 1.00	CATION -	City or Town	State
e 6 may ector, p		1	oval trom State	Bel Ac	L ME	ther place).	3dns. 5/	6/95	Bel	2 Air	. Mar	yland
BALTIMORE, MARYLAND er death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. il examiner must be notified at once.		21. SIGNATURE OF PUNETAL SERVICE LIC	B -	4/	/	Duda	-Ruck Fu	ineral	Home	06 T	undal	k, Inc.
B/ rs after of n by the removal.	\vdash	23. PART I. Enter the disesses, Dr c	complications that o	arread the day	th Do r	7922	Wise AL	re. Du	ındall	2. MI	212	22
hours d in t or re		anock, or hasrt fallure.	List only one cause	on ach lina.	ui. OD i	iot ainar tria mic	ida bi dying, au	ich as cardia	ic or respi	atory arr	eat,	Approximata Interval Between
within 24 Inpletely fille cremation,		IMMEDIATE CAUSE (Final disease or condition	CIT	6/00	1							2 days
760 ad within 24 ompletely fille II, cremation, event, the		reaulting in death)	DUE TO (OF	R AS A CONSEQU	JENCE OF	F):						accurs
68 ecute and co bunia	TION	Sequentially list conditions, If sny, leading to immediate	DUE TO (OF	R AS A CONSEOU	JENCE OF	F):					200	
BO) cate be hysician prior	<u>S</u>	cause. Entar UNDERLYING CAUSE (Disease or injury	D									
O. 이 결국 보	CERTIFICATION	that initiated eventa resulting in death) LAST	d. Cano	AS A CONSECU	JENCE OF	F):						
ORDS, P that the death ed by the atten th and Mental H any Injury, o		PART II. Other significant condition	s contributing to de	sth but not ra	suiting i	in the underlyln	g cause given in	n Part i. 2	4e, WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
	MEDICAL	Diabetes	suffice						PERFOR	-	CO	AILABLE PRIOR TO IMPLETION OF CAUSE DEATH?
w requires been sign or, of Heaf		DID TOBACCO USE CONTE			H YE	S D NO E	UNCERTA	IN D			1 [YES 2 NO
12 eg 8 eg [SICIAN	25. WAS CASE REFERRED TO MEDICAL			-	H (Check only one)	DIACEKIA	114 🖂]				
VITA SIAN: The rifficate h he State f or item	Sic	1 YES 2 NO	HOSPITAL:	R/Outpatient 3	DOA	OTHER: 4 Nursing Horn	e 5 🗆 Residence	8 Other (Specify)			
PHYSIC This ce with th	ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJ (Month, Day,		28b. TIM	URY WO	URY AT PRK?	28d. DESCR	RIBE HOW IN	JURY OCC	CURED	
ISIC TTENDI TTOR: A after d	ETED B	3 Suicide 8 Could not be determined	28s. PLACE OF IN building, stc.	NJURY At hom . (Specify)	e, form, s	street, tectory, offic	a	28t. LOCAT	ION (Street a Town, State)	nd Number	or Rural Route	Number,
OR A DIRECT HOURS	PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my	knowledge, deal	h occurre	ed at the time, date	and place, and du	e to the cause	e(a) and man	ner as stet	ed.	
	COMPL	one) 2 MEDICAL EXAMINE										d manner ea stated.
(Fil	w	296. SIGNATURE AND TITLE OF GERTIFIER	1				29c. LICENSE NU	JMBER		29d. DATE	E SIGNED (Mo	onth, Day, Year)
C P	TO B	much my	nto h	m			D4196	8		•	5/4/0	75
^		MICHAEL D. N	ARTIAL.	OF DEATH (ITEM		Prine) Saltima	ve N	10	212	22_		
17		MAY 0 8 1995	A REGISTRAR'S	IGNATURE		Jan I Ima	(

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It	enl, Film723,5/8/95,1t for 1 - STATE REGISTRAR	STATE OF MAR		RTMENT OF		IENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)	WILHELMINIA 1	OMNE	imin	le	2. DATE OF DEATH MONTH DO	4 95	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 212-09-1028 9e. FACILITY NAME (If not institution, give st	1 🗆 M 2 💥 F	GE (In yrs. lest birthday) 97 YRS.	IF UNDER 1 YEAR MONTHS DAYS 9b. CITY, TOWN	F UNDER 24 HRS. HOURS MIN. OR LOCATION OF DEA	7. DATE OF BIRTH (Month, Day, Year)	898	Maryland Y OF DEATH
TOR	RESIDENCE OF DECEDENT	sing Ceny	46	Balt	More	MOZIZA	Ba]	Ltimore
DIRECTOR	10a. STATE 10b. COUNTY	altimore	10c. CI1	TY, TOWN OR LOCA	Essex			10d. INSIDE CITY LIMITS? 1 YES 2 NO
RAL	100. STREET AND NUMBER			10	Y. ZIP CODE 2122	0.1	10g. CITIZE	EN OF WHAT COUNTRY?
BY FUNERAL	l Eastern Ave	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 XINO	If yes, s		C ORIGIN? (Specify Yes, Puerto Rican, etc.)	or No- 1	4. RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	USUAL OCCUPATION Work done during more retired.)	ost of working	166. KIND OF BUS		SSacs
	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	E (First, Middle, Malden		
TO BE	Charles Boder 190. INFORMANT'S NAME (Type/Print) Thelma Adams	iburg	196. MAILING 202 N	AOORESS (Street	end Number or Rural Ro	cy Maier Outo Number City or Town east Win	n, State, Zip C	AAven Florio
	20a, METHOD OF DISPOSITION 20 Netrol 2 Cremation 3 Remo 4 Donation 6 Other (Specify) 31. SIGNATURE OF PUNERAL SERVICE LICE	wat from State	20b. PLACE AND DATE cemelery, cremetory or or Moreland	Memori 22. NAME A Conn	al 5/8/9 ND ADDRESS OF FACE elly Fur	5 B	alitm me of	
	23. PART I. Enter the diseases, or c shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	ATHE	each line.	one H	ode of dying, auch	as cardiec or reapi	ratory arres	at, Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE O					
PHYSICIAN: MEDICAL C	PART II. Other significent conditions	contributing to death		in the underlyIn	g cause given in P	ert I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Chec	k only one)		
rsic	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/0	outpatient 3 DOA	OTHER:	ne 5 🗆 Residence 6			
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending Accident Investigation	26e. DATE OF INJUR (Month, Day, Yea	(Y 286, TIM	JURY W	JURY AT DRK? YES 2 NO	26d. DESCRIBE HOW II	YJURY OCCU	RED
	3 Suicide 6 Could not be 4 Homicide determined	25e. PLACE OF INJU- building, atc. (S	JRY — At home, term, pecify)	street, factory, offic	e :	281. LOCATION (Street e City or Town, State)	nd Number or	Rural Route Number,
COMPLETED		HAN: To the best of my kn						ceuse(e) end manner ee stated.
TO BE C	295. SIGNATURE AND RITLE OF CERTIFIER	1 Dun			29c. LICENSE NUMB			SIGNEO (Month, Day, Year)
-	Dr. Michael Sute		овати (птем 27) Лури 1 in Scruar		al			



BALTIMORE, MARYLAND 21215-0020

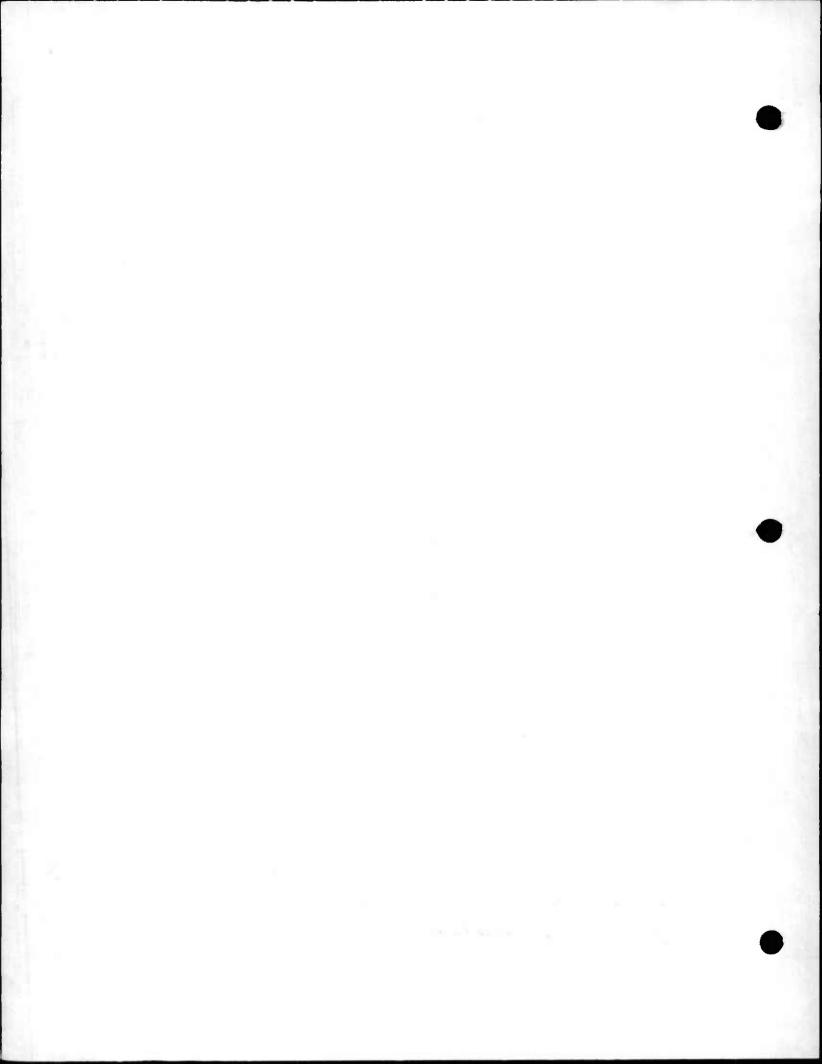
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P.0.
RECORDS,
VITAL
OF
DIVISION

										95	13	3957
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR	RTMEN	T OF H	EALTH DEA	AND	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)									DAY	YEAR	TIME OF DEATH
	HALBERT WILLI	AM MCMUI	6. AGE (In yrs. la:	_	~	NFAB	7 : 200		MAY 5,	1995		6;10 A M
	212-36-0628	1 🗶 M 2 🗆 F	56	YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	- 1	Country)	aryland
	9a. FACILITY NAME (If not institution, give				9b. CIT	Y. TOWN C	OR LOCATI	ON OF D		18,1989	TY OF DEAT	aryland
S.	SAINT JOSEPH	MEDICAL	CENTER	2					LAND	BALT		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT		OBNIE					MIXI.	LIAND	DALI		
JIR	MD	Harford		10c. C11	H	OR LOCAT	de (0	_			d. INSIOE CITY LIMITS?
	10e. STREET AND NUMBER					101	. ZIP COD	E	€	10a, CITIZI		YES 2 NO
ER/	421 Brian Garth	i					210	078			S.A.	
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 2	RMED	13.	If yes, sp	ENOENT Cobs	ırı, Mexica	NIC ORIGIN? (Specify 1 an, Puarlo Rican, atc.)		14. RACE — Black, Wi	
R .	3 Widowed 4 Divorced						21					White
ITE	15. DECEDENT'S EDI (Specify only highest grad	le completed)	(G	CEDENT'S live kind of Do NOT u	work done	during mo	ON ist of worldi	ng	18b. KIND OF B	USINESS/INDU	STRY	
PL	Elementary/Secondary (0-12)	College (1-4 or 5+	,	uck .					Armore	d Trucl	kino	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			uck .	DIIV	CI	18. MOT	HER'S NA	ME (First, Middle, Maide e Marie C		KING	
BE (Robert Lacey Mc M	lullen					L					
5	Darlene R. Mc M	ſullen	19	421	Bria	s (Street a n Ga	rth	Havr	Route Number City or To e de Grac			
	20a. METHOD OF DISPOSITION 1 [X Burlat 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State	20b. PLACE	AND OATE	of DISPO	sition(Na ery	ame of		5/8/95 ^{20c. L}	ocation — ci	ity or Town,	Stata
	21. SIGNATURS OF FUNDING. SERVICES	The	1h		7	110	Bela	ir R	oad Balti	ippel i	Funer	al Home In 206
	23. PART I Enter the diseases of shock, or heart failure. IMMEDIATE CAUSE (Final disease/or condition	. List only one caus	se on agch line	6,					h aa cardiac or rea	piratory arres	st,	Approximata Interval Between Onset and Death
	disease/or condition resulting in death)	a. ACUTE	MYOCAF OR AS A CONSE			IFA R	CTI	ON				6 DAYS
z		CORONA				SEAS	E					YEARS
ERTIFICATION	Sequentially list conditions, if any, leading to immediate		OR AS A CONSE		,							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	HYPERC				[A						YEARS
TE	that initiated events resulting in death) LAST		OR AS A CONSEC									
CEF		d. RHEUMA										YEARS
AL	PART ii. Other significant condition	ns contributing to	death but not r	esuiting	in the u	nderlying	cause (givan in		N AUTOPSY PRMED?		RE AUTOPSY FINDINGS
MEDICAL	Peripheral Vaso Right Total Hi	Deplac	sease	for	n 4				1 D YES	² X NO	CO	MPLETION OF CAUSE DEATH?
ME											1 [YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAL		E OF OEAT			UNC	ERTAI			<u> </u>	
SIC	EXAMINER?	HOSPITAL:			OTHE	R:			6 Other (Specify)			
Ή	27. MANNER OF DEATH	28a. DATE OF I	INJURY	28b. TIM	E OF	28c. INJU	URY AT	siderice	28d. DESCRIBE HOW	INJURY OCCU	REO	
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Month, De	y, rear)	INJ	URY M		RK? 'ES 2	NO				7
ED E	3 Suicide 6 Could not be	28a. PLACE OF building, (INJURY — At ho etc. (Specify)	me, ferm, r	treet, fac	tory, office	,		261. LOCATION (Street City or Town, State		Rural Route	Number,
MPL	29a. CERTIFIER (Check only one)	ICIAN: To the best of r	my knowledge, de	ath occum	d at the	lime, data	and place,	and dua	to the cause(a) and m	inner as stated	١.	
COMPL	2 MEDICAL EXAMINE		amination and/or i	investigatio	n, in my o	opinion, de	eath occur	ed at the	time, data and placa, a	nd due to the	cause(a) and	manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIE	me						NSE NUN	IBER	1		nth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CAUS	F OF DEATH AYES	M 27) (5m-	Orient		D258	386		1 5	5.5	.95

D25886 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lilia Ceballos, M.D., 7620 York Road, Towson, Maryland 21204

31. DATE FILED (Month, Day, Your)

MAY 0 8 1995



95 | 3958

			1 - FOR REGISTRAR	STATE OF N	MARYLAN	ID / DEPAR	TMENT OF	HEALTH AND	MENTA	L HYGIEN				
			1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATN		3. TIME OF DEATH		
		3	GRACE MCDEARMO						MAY	5, 19	995	1:29 P M		
			4. SOCIAL SECURITY NUMBER	5. SEX		rs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH h, Day, Year)	1	BIRTHPLACE (State or Foreign Country)		
	should		406 09 2379 9s. FACILITY NAME (If not Institution, give		74	YRS.				y 1, 1	L920	Ky.		
	2.3	DIRECTOR	THE JOHNS HOPKINS		L			ORE CITY	EATN		9c. COUNT	A OF BEATH		
	ges 1	1 1 1	10s. STATE 10b. COUNT			10c. CIT	Y, TOWN OR LOC	ATION		*		10d. INSIDE CITY		
	burial-transit permit. Pages 1.		Md. Carr	011			Sykesv	ille			,	LIMITS?		
	per	\¥	10a. STREET AND NUMBER				1	Of. ZIP CODE			10g. CITIZE	EN OF WHAT COUNTRY?		
an.	ransit	FUNERAL	6512 White Roc					21784			U.S	. A.		
20 Tysici	urial-t	큔	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDEN FORCES? 1			13. WAS DE	CENDENT OF HISPA	NIC ORIGII	1? (Specify Ye	s or No- 1	4. RACE — American Indian, Black, White, etc.		
5-0020	the b	B	3 Wildowed 4 Divorced	IF YES, GIVE W	MAR OR DATE:	3		S 2 NO Specif		208, 30,		White		
21215-0020 or attending physician.	e as		15. DECEDENT'S EDU	JCATION	16	a. DECEDENT'S	USUAL OCCUPAT	TON	166	KINO OF BU	ISINESS/INDU			
2121 al or atte	for use		(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 -		(Give kind of a life. Do NOT us	work done during a	nost of working	"		011120011100	VIII)		
Ospita	thed	로	H.S.	+2		Regis	stered 1	Nurse		Hos	pital	Health Care		
MARYLAND retained by the hospit	detached once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First,					
34	d be	BE	William Taylor	Shockey				Matti	e Ar	nett				
AA F	5 should notified	0	19a. INFORMANT'S NAME (Type/Print)			196. MAILING	ADDRESS (Street	and Number or Rural			vn, State, Zip C	code)		
ار م الله	page 5	-	Fielding U. McDo	earmon		6512 I	Rock Ro		svil	le, Md	. 212	7 21784		
ORI S may			20s. METHOD OF DISPOSITION 1 Description 2 Cremetion 3 Rem	novel from State	20b. PL	ACE AND DATE	of disposition (finer place) Mem. Pa		OAT			ty or Town, State		
M age	direc er m		4 Donation 5 Other (Specify)	CENSEE	Lake	e View				1995	Sykes	ville, Md.		
BALTIMORE, MARYLAND 2 hours after death. Page 6 may be retained by the hospital	the funeral director, yeal.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Haight Funeral Home P.O. Box 195 Sykesyille, Md. 21784											
irs aft	d in by the or removal medical		23. PART I. Enter the diseases, or shock, or heart failure.	complications that	t ceused th	e deeth. Do r	ot enter the m	ode of dying, aud	h es card	liec or resp	iratory arres	it, Approximate		
4 hou			IMMEDIATE CAUSE (Final	List Only One Ced	1							interval Between Onset and Death		
É	ompletely fille I. cremation, event, the		disease or condition resulting in death)	a/	16/1	ic Pis	Sechin					Ears.		
68760 ecuted with	al. cre			OUE TO	(OR AS A CO	NSEQUENCE OF	7:							
	sician and con infor to burial, traumatic ex	NO N	Sequentially list conditions,	b	10B 46 4 60									
O B	ysician prior to traum	ATI	if any, leading to immediate cause. Enter UNDERLYING	506 10	(OR AS A CO	NSEOUENCE OI	-):							
. ≝	ing phys giene pr other 1	ERTIFICATION	CAUSE (Disease or Injury that initieted events	C. DUE TO	(OR AS A CO	NSEQUENCE OF	<u>ገ</u> :							
P.O	Hygie Or Ot	듄	resulting in death) LAST	4								İ		
	y the attending physician id Mental Hygiene prior to injury, or other traun	0	DARK II OM and Miles	d,										
O E	× 0	AL	PART II. Other significent condition	na contributing to	deeth but r	not resulting i	n the underlyli	ng ceuse given in	Part i.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
S E	Health a	EDIC							_	1 TES 2	□ NO	COMPLETION OF CAUSE OF DEATH?		
RECOR	5 6 6	Σ							_			1 TES 2 TO		
	Dept.	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA					N 🗆					
VITAL IAN: The law		S	EXAMINER?	HOSPITAL:	2		H (Check only one OTHER:)						
OF VI	the the	HYS	1 TYES 2 NO 27. MANNER OF OEATN	1 Inpatient 2 2			4 - Nursing No	me 5 Residencs						
OF	with with	<u>a</u>	1 Natural 5 Pending	(Month, De	ay, Ybar)	26b. TIM	URY W	JURY AT ORK? YES 2 NO	26d. OES	CRIBE HOW I	NJURY OCCU	RED		
ONG	After death s mar	6	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE O	F INJURY — A	Al home form s	treel, factory, offi		281 1.00	ATION (Stant	and North and	Rural Route Number,		
/ISION ATTENDING			4 Homicide 6 Could not be determined	building,	etc. (Specify)		areat, leatery, orn			or Town, State)		Hurer Houte Number,		
DIVISION OR ATTENDING F	DIRECTOR: Atter hours after death item 28 is ma	9	296. CERTIFIER	ICIANI TO BUILDING	a de Ularea				1.15.1					
HOSPITAL	4 2 =	COMPL	(Check only one) 298. CERTIFIER 1 CERTIFYING PHYS (Check only one) 2 MEDICAL EXAMINE									cause(s) and manner as stated.		
운	TO THE FUNER be filed within IMPORTANT:	шШ	296. SIGNATURE AND TITLE OF CERTIFIE	R / M	11			29c. LICENSE NUI	MBER		29d. DATE S	SIGNED (Month, Day, Year)		
E PE	TO THE be filed	0 8	111. Boy	of Dul	Ushi	,		698.	34					
		۲	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUS	SE OF DEATH	(ITEM 27) (Type,	Print)		·			- /3		
6	1		M. Band 4	allerado	A 104	ns Hon	Kins 14	e. jul	60	211.0	0/R ST	5-5-95 reel balkman		
			31. DATE FILED MOST 1995	A STREET,	וליו אלטוב בי לו	RE								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY CHINEDAL STORY	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
i examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or IVM 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
this for section has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the fate bept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this can act he been signed by the attending physician and completely filled in by the form the filed within 72 hours after death with the fate Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whours after death. Page 6 may be retained by the hospital or attending physician.
	(

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	* REGISTRAR		CE	-17	CAIL	F DEA	111	H	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	-			_			2. DATE OF D	EATH	-		3. TIME OF DEATH
. 7	CARL ARTHUR N	COLOT CONT						MONTH	DAY		YEAR	
1								MAY		<u> 1995</u>		2:26 A M
1 7	4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. lest	t birthday)	IF UNDER 1 YE		R 24 HRS.	7. DATE OF B	IRTH		S. BIRTH	IPLACE (State or Foreign
1 1	101-60-2421	1 X M 2 - F	30	YRS.	MONTHS DA	8 HOURS	MIN.	MAY 4	796	55 h	VOINT	York
	9e. FACILITY NAME (If not institution, give		-					MAY 4, 196				
		,			9b. CITY, TOV	N OR LOCAT	ION OF DEA	DEATH 9c. COUNT			TY OF D	PEATH
H	Stella Maris Hosp	oice		Towson						Baltimore		
K	RESIDENCE OF DECEDENT			20.20								
DIRECTOR	10e. STATE 10b. COUNT	Υ		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY
<u>E</u>	Maryland N/A				CANAL CT	D-1.	L	_				LIMITS?
		1				ват	timor	е				1 X YES 2 NO
4	10e. STREET AND NUMBER					10f. ZIP COD	E			10g. CITI	ZEN OF V	WHAT COUNTRY?
FUNERAL	1001 St. Paul Str	eet Ant 8-	·H			2	1202			1	USA	
Z I	11. MARITAL STATUS										UDA	
5		12. WAS DECEDENT EVE FORCES? 1 2	R IN U.S. ARI	MED	13. WAS	DECENDENT	OF HISPANII	C ORIGIN? (Sp. Puerto Rican	ecify Yee	or No-	14. RACE	E — Americen Indien, k, White, etc.
	1 Never Merried 2 Merried	IF YES, GIVE WAR OF				YES 2 NO		, Puerto Hican	, arc.)	- 1	Speci	M
B	3 Widowed 4 Divorced				-						Open	"White
Ω.	15. DECEDENT'S EDU	ICATION	16a DEC	CEDENT'S	JSUAL OCCUP	ATION		ter Kini	OF BUILD	INESS/IND	HOTOW	
COMPLETED	(Specify only highest grade	completed)	(GA		ork done during		ing	IOD. KIN	or bosi	INE 35/INU	USINI	
<u>" </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	l l									
4		4	Mana	ager'	s Assi	stant		Res	taura	ant		
ő	17. FATHER'S NAME (First, Middle, Last)				***************************************	18 MOT	HER'S NAM	E (First, Middle	Maidan S	(waama)		
	Harris Arth	us Micheles				10. 110.				,	_	1
B		ur Nichorso	П				S	orver	g Pat	rici	a Pe	ederson
	19e. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS (Str	et and Numbe	r or Rural Ao	oute Number, C	ity or Town,	State, Zip	Code)	
2	Solveig Nelson							sapequ				1762
							Habi		_			
	20s. METHOD OF DISPOSITION 1 Buriel 2 CCremetion 3 Rem	loval from State	20b. PLACE A	ND DATE O	FDISPOSITION	(Name of		DATE		ATION —		
	4 Donation 5 Other (Specify)	P	letro	Crem	atory,	Inc.(05/06	/95 l	Balt	timon	ce. I	MD
- 1	21. SIGNATURE OF JUNERAL SERVICE EN	CENSEE	-		22. NAM	AND ADDRE	SS OF FACI	LITY			, -	
	, sera	· Mar May	-	Cremation Society of Maryland						d		
	George E. Macl	Nahh		299 Frederick Rd. Baltimore, MD 21228						21 220		
_												21220
	23. PART i. Enter the diseases, or shock, or heart failure.	List only one cause or	sed tha dei	ath. Do n	ot enter the	mode of dy	ing, such	as cardiac	or reepira	atory arn	est,	Approximate
- 1	IMMEDIATE CAUSE (Fine)		+	•						0		Intervel Between Onset and Death
							1	*		1/		
- 1	disease or condition	10,10	1			10	/			X	15.	-1 2 5
	disease or condition resulting in deeth)	· lutor	m	mu	ne	Dex	lece	enc	4 X	Syn	dre	The 3
		DUE TO (OR A	M) S A CONSEO	MUL DUENCE OF	sel.	Deg	la	enc	4 X	Syn	dre	The 3
Z	reculting in deeth)	DUE TO (OR A)	M) S A CONSEO	MUL DUENCE OF	jel :	Deg	lece	enc C	4 X	yn	dre	The 3
ION	resulting in deeth) Sequentially list conditions,	DUE TO (OR A		DUENCE OF	:	Deg	lece	enc (y x	yn	dre	The 3
ATION	Sequentielly list conditions, if any, laeding to immediate	b		DUENCE OF	; :	Deg	leci	enc C	4 x	Syn.	dre	one 3
ICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	bDUE TO (OR A:	S A CONSEO			Deg	ece	enc C	4 x	Syn.	dre	ome 3
LIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b	S A CONSEO			Deg	eci	enc	4 x) yn	dre	ome 3
RTIFICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	bDUE TO (OR A:	S A CONSEO			Deg	leci	enc C	y x) yn	dre	ome 3
CERTIFICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	b	S A CONSEO	UENCE OF):				y x	Syn.	dre	ome 3
AL CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b	S A CONSEO	UENCE OF):				WAS AN A	UTTOPSY	dre 24b.	WERE AUTOPSY FINDINGS
CAL CERTIFICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	b	S A CONSEO	UENCE OF):					UTTOPSY	24b.	AVAILABLE PRIOR TO
DICAL CERTIFICATION	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	b	S A CONSEO	UENCE OF):			ort i. 24e.	WAS AN A	ULTTOPSY MED?	24b.	
EDICAL	Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	b	S A CONSEO	UENCE OF):			ort i. 24e.	WAS AN A PERFORM	ULTTOPSY MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b	S A CONSEO	OUENCE OF	the underl	ying couse	given in P	ert i. 24e.	WAS AN A PERFORM	ULTTOPSY MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
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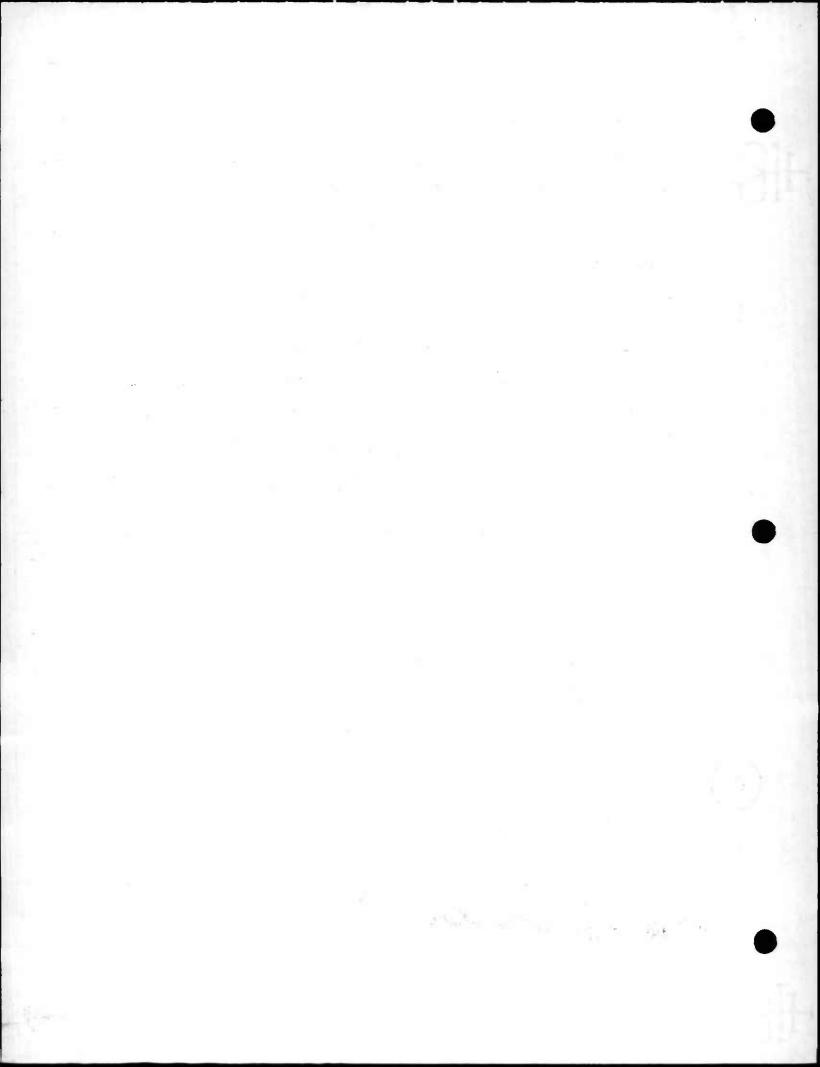
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



ertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death, Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

N OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPIN OF ATERIOR PHYSICIAN: The law requires that the death certificate be executed within 72 hours and regar. Page 5 should be detached to the FUNETAL WESTIGNER. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the attending physician and completely filled in by the funeral director, page 5 should be detached by the attending physician and completely filled in by the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director, page 5 should be detached by the attending to the funeral director and the funeral

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND /	DEPARTMEI ERTIFICAT				GIENE	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	ATH	3. TIME OF DEATH
	ERNEST		0.1	TVER	JR.	MONYH		/EAR
	4. SOCIAL SECURITY NUMBER 5. SE	EX 6. AGE (In yrs. last		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRD		12:40A BIRTHPLACE (State or Foreign
	214-50-2130	M2 DF 49	YRS. MONTH	S DAYS	HOURS MIN.	(Month, Day, Y	bar)	Country)
	9a. FACILITY NAME (If not institution, give street and	d number)	9b. CI	TY. TOWN OF	R LOCATION OF D	AUG 25		Y OF DEATH
R	SINAI HOSPITAL.				ore Ci		JE. COOK	N/A
DIRECTOR	RESIDENCE OF DECEDENT				.010 01			14/11
H	10e. STATE 10b. COUNTY	. / .	10c. CITY, TOWI	N OR LOCATE	ION			10d. INSIDE CITY
	MARYLAND	VA		BA	LITIM	ORE C.	174	LIMITS?
AL	10e. STREET AND NUMBER			10f.	ZIP CODE			N OF WHAT COUNTRY?
E	125 LUNDHUR	25T STREE	T		21:	229	1	15A.
FUNERAL		AS DECEDENT EVER IN U.S. ARI		3. WAS DECE	ENDENT OF HISPA	NIC ORIGIN? (Spec	Ify Yes or No- 14	I. RACE — American Indian,
ВУ		ORCES? 1 TYES 2 N YES, GIVE WAR OR DATES			2 NO Special	en, Puerto Rican, at fy:	Ic.)	Black, White, atc. Specify:
					/ \			BLACK
TEC	15. DECEDENT'S EDUCATION (Specify only highest grade complete	rted) (Gr	CEDENT'S USUAL	ne during most	N it of working	16b, KIND (F BUSINESS/INDUS	TRY
3	Elementary/Secondary (0-12) Colle	ege (1-4 or 5 +)	Do NOT use retired	,	1.1401			A
COMPLETED	11 GRADE		HNTEN	VANCE	E WORK	ER SOCIA	L SECURI	MY ADM.
00	17. FATHER'S NAME (First, Middle, Last)	81.	1100	0	18. MOTHER'S NA	AME (First, Middle, A	Aalden Surname)	/
BE	ERNEST		VER :		WILL	IE M	1AE	FLOOD
2	19a. INFORMANT'S NAME (Type/Print)	2. 0 - 196	. MAILING ADDRE			Route Number, City	or Town, State, Zip Co	ode)
		AGE 1	125 L		YURST	STREET	BALTON	40,21229
	20g. METHOD OF DISPOSITION 1. A Buriel 2 Cremation 3 Removal fro		MDDATE OF DISP	od.			De. LOCATION - CIT	· Control Section
. 4	4 Donation 5 Other (Specify)	- PBU	TUS	CEM	ETERY	5-8-95	ARBUT	45,MD,
Ш	21. SIGNATURE OF FUNERAL SERVICE CHENSES	. ()			D AGORESS OF FA		NERAL HO	ME D A
	· Charle	Mar	— i	913 W	V. BALTI	MORE ST.	, BALTIM	ORE, MD.21223
	23. PART I. Enter the diseases, or compile	cations that caused the dar	ath. Do not ent					
	shock, or heart failure. List on IMMEDIATE CAUSE (Final	nly one cause on each line.						Interval Between
	disease or condition	GULVEHOT WY	T CMMILE	2 01	LIPST			Onset and Deat
		GUNSHOT WO	DUMD T	0 C	HEST			
z	disease or condition		-	0 C	HEST			
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CATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQ	OUENCE OF):	o Cl	HEST			
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FURENCE UPERIAR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed that it is certificate bept. of Health and Mental Hygiene prior to burial, cremation, or removal.

LEDING THE HOSPITAL OF ATTENDING PRIOR PR

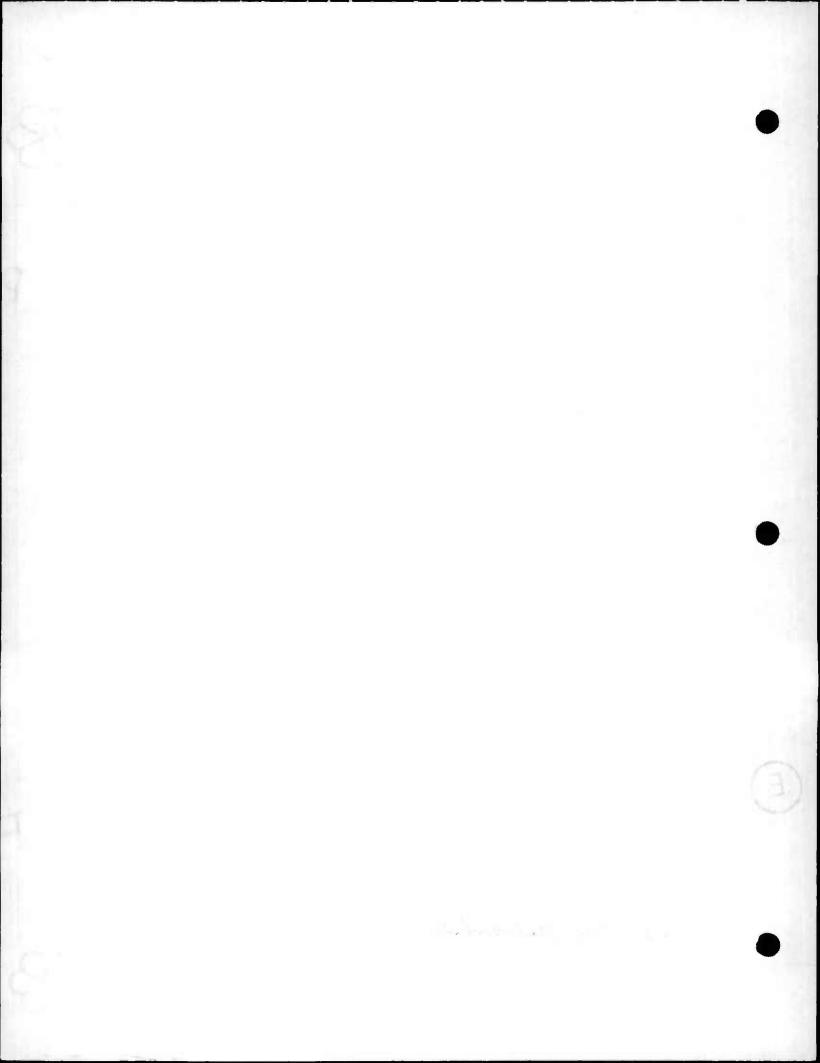
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CERTIF	ICATE OF DEATH	REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH		3. TIME OF OEATH		
	Roberta Ph	illips				AY YEAR			
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	11 199	TTNPLACE (State or Foreign		
	217-01-0007	1 🗆 M 2 😿 F	84 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year)	Cou	intry)		
	An Eschitty MAME		0 / 1110.		08/22/1	4 186	140. MG		
	9a. FACILITY NAME (If not institution, give st			96. CITY, TOWN OR LOCATION OF					
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5	RESIDENCE OF DECEDENT								
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCATION			10d, INSIDE CITY LIMITS?		
	MARYIAND	NIA		BAITIMORE			JES 2 □ NO		
AL	10a. STREET AND NUMBER	1 1	0 1	101, ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
H	3202 DORI	THAN	Rd.	212	15	//	15A		
FUNERAL	11. MARITAL STATUS	12. WAS DECEOENT	EVER IN U.S. ARMED	13. WAS DECENOENT OF NISPA	NIC ORIGIN? (Specify Va	14 B/	ACE — American Indian,		
	1 Never Married 2 Married	FORCES? 1	YES 2 NO	If yes, specify Cuban, Mexic	an, Puerto Rican, atc.)	81	eck, White, etc.		
B	3 Wildowed 4 Divorced	IF TES, GIVE WE	N ON DATES	1 TYES 2 NO Spec	rry:	Sp	ecity: RIDIX		
8	15. DECEDENT'S EDUC	CATION	16a DECEDENT'S	USUAL OCCUPATION	16h KIND OF BU	ISINESS/INOUSTRY	DIMO		
IEI	(Specify only highest grade	completed)	(Give kind of v	vork done during most of working	100, KIND OF BU	SINESS/INOUSTRI			
12	Elementary/Secondary (0-12)	College (1-4 or 5+)	D	(;	11/2				
Σ			1/om	65 DC	HON	NE			
COMPLET	17. FATHER'S NAME (First, Middle, Last)	11.0.1		16. MOTHER'S N	AME (First, Middle, Maider	Surname)			
BE	MICHAEL DO	HNSON	F 10	LUC.	V BYT	9			
	19a. INFORMANT'S NAME (Type/Print)	-	19b, MAILING	AOORESS (Street and Number or Rural	Route Number City or Tox	vn, State, Zip Code)	1		
유	MARGARET Sm	1/4	300	2. Droithai	Rd. B	alla 1	11/ 2/215		
	29a METNOD OF DISPOSITION		20h BLACEANDOATE	OF DISPOSITION (Name of	1 2022 1 202 1	TIT ().	10 0 2 2 2		
	1 Burial 2 Cremation 3 Remo	oval from State	cemetery, crematory or of		DATE 20c. LO	CATION — City or	Town, State		
	4 ☐ Donation 5 ☐ Other (Specify)		WESTER	STAR	7/5/95 /	241-17M	OFF MI		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND ADDRESS OF F		FINITAL	1 Home		
	1	(0)		DERKICK C	JONES	ourself	1 30/10		
	Jenne Ax	- 1		4611 PARK H	=19175 HV	E. KSA14	n. 14/1 2/2/5		
	23. PART I. Enter the diseases, or c shock, or heart fellure. I	Difference that consider that consider the consideration that consider the consideration that consideration the consideration that consideration t	ceused the death. Do r e on eech line.	not enter the mode of dying, au	ch áa cerdlec or reep	elratory erreet,	Approximate		
: 1									
	IMMEDIATE CAUSE (Finel	0 1		1			Interval Batween Onset and Death		
	disease or condition	and	- Mascu	Over and	Nazzaru L	An	Onset and Death		
		- Cardo	OR AS A CONSEQUENCE OF	lar and	Mapirati	nam.	Onset and Death		
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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First									2. DATE OF DEAT	H DAY	YEAR	3. TIME OF DEATH
		LESTER	PACK								MAY	2, 19	995	11:55 P M
		4. SOCIAL SECURITY NUME		5. SEX		rs. last birthday YRS.	MONTHS	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Yea	rd .	8. BIRTH	PLACE (State or Foreign
3 should		216-40-1272 9a. FACILITY NAME (If not in	nstitution, give s	42	5	2 YRS.	9b. CITY	. TOWN	OR LOCATE	ON OF DE	APRIL 2		MAK I	
2, 3 sh	CTOR	THE JOHNS			TAL			ltim		Cit	/ -			EATH
-	5	RESIDENCE OF DEC	10b, COUNTY	,		100 C	TY, TOWN							
. Pages	DIRE	MARYLAND	100. 000.	N/A		100.0			ORE	CITY				10d. INSIDE CITY LIMITS? 1 TY YES 2 NO
permit.	ERAL	10e. STREET AND NUMBER		11/11				10	f. ZIP CODI	E		têg. CIT	ZEN OF W	HAT COUNTRY?
- TS	Ë	501 E. PRE	STON S	TREET ,	APT.#5					202	USA.			
020 physician. burial-transit	FUN	11. MARITAL STATUS SI	NGLE Married	12. WAS DECEDER FORCES?	YES 2	NO NO					IIC ORIGIN? (Specifor, Puerto Ricen, etc.		14. RACE Black	- American Indian, , White, etc.
5-0020 nding physic is the burial	B	3 Widowed 4 Divo		IF YES, GIVE	MAR OR DATES	8		1 YES	2 X NO	Specify	r:		Specifi	
21 88 atte	윤	15. DEC (Specify ont	EDENT'S EDU	CATION completed)	164	a. DECEDENT (Give kind o	work done	CCUPATH during me	ON ost of working	10	16b. KIND OF	BUSINESS/INC		HOIC
	LET	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Itte. Do NOT	use retired.)			.9				
AND 2 he hospital detached for	COMPL	9th GRADE 17. FATHER'S NAME (First, M	liddle, Last)			LAB	ORER		I sa MOTT	HED'S MAI	AERO S	SPACE	Com	PANY
8 8 8 A	Ы	UNKNOWN							1	LDRE			PACK	•
MARY retained by 5 should bu notified al	TO B	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILIN	G ADDRES	S (Street e			Route Number, City or			
	F	JOSEPH		ACK		9316	TULS	EME	RE RO)AD,	RANDALS	TOWN, M	D. 2	1133
E - W		20s. METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	cameter	ACE AND DATE	other plecel				1	LOCATION		
Page 6 m director.		4 Donation 5 Other 21. SIGNATURE OF FUNERA	-	ENSEE	KIN	G MEMO	RIAL	PARI	K CEM	ETER	RY 5-5+95	WOODL	AWN,	MARYLAND
ALTIMO death. Page 6 tuneral directo J. examiner mu		+(Wa		(P	h -		j	OSE	РН Н.	BRO	OWN JR FU	INERAL	HOME	,P.A.
Es after on by the removal.		23. PART i. Enter the di	iseases, or o	complications the	ot caused th	e death Do	1	913	W. E	SALTI	IMORE ST.	. BALT	'TMOR	E. MD.21223
De of E		shock, or hi	aart tanure.	List only one car	use on anch	lina.	not antar	tile inc	ou or uyi	ng, auci	n as cardiac or r	eapiratory ari	681 ,	Approximata interval Between Onset and Death
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7 8 8 9	CERTIFICATION	resulting in death) LAS	T L.	1										
의 분조를		PART II. Other significa	nt condition	s contributing to	death but r	not resulting	In the ur	dariyin	g causa g	ivan in	Part i. 24a. WAS	AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
that the led by the and the and In	EDICAL	Persist	nt Ne	anologic	Veget	n tive.	Stat	e			PEF	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
pquires the signed of Health and hows and	ME								,					OF DEATH?
The law requires that the has been signed by ate Dept. of Health and m 23 shows any	Ä	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆			
AN: The lav lificate has s State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	0 MEDICAL	HOSPITAL:		PLACE OF DE	OTHER	₹:						
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E E 5 E	ВУ Р		Pending Investigation	(Month, D	lay, Ybar)	11	JURY M	WO	PRK? YES 2 [NO			NO.	
DR: After ter death 8 is mai		3 Suicide 8	Could not be	28a. PLACE C building,	of INJURY — A	At home, farm.	atreel, fact	ory, offic			28f. LOCATION (Str. City or Town, S		or Rural A	oute Number,
E 4 2	ETED		datarmined											
TAL OR AL DIRE 72 hours II item	COMPL										to the cause(a) and			
TO THE HOSPITAL TO THE FUNERAL SE filed within 72 IMPORTANT: If	00	2 MEDI			xamination and	d/or Investigat	on, in my o	pinion, d	leath occur	ed at the	lime, data and place	, and dua to th	e cause(s)	and menner as stated.
불 분 를 중	BE	296. SIGNATURE AND TITLE	OF CERTIFIER	1000	most.	mi	>			NSE NUM		29d. DAT	SIGNED	(Month, Day, Year)
₽ P 2 ₹	2	30. NAME AND ADDRESS OF	PERSON WH	COMPLETED CAU	SE OF DEATH	(ITEM 27) (Typ	e, Print)		11	161	15) 4	72
5		AL DATE FILES AL	J.A	. Unde	rwood	, mi	>.,	Joh	ins)	topl	cins Ho	pital	Bul	hmore, mo
		MAY 0 8 19		la d'audio	R'S SIGNATUI	T.								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the four that the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the law in the Completely filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burnal, common or removed.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other transmalls event, the medical examiner must be notified at once.

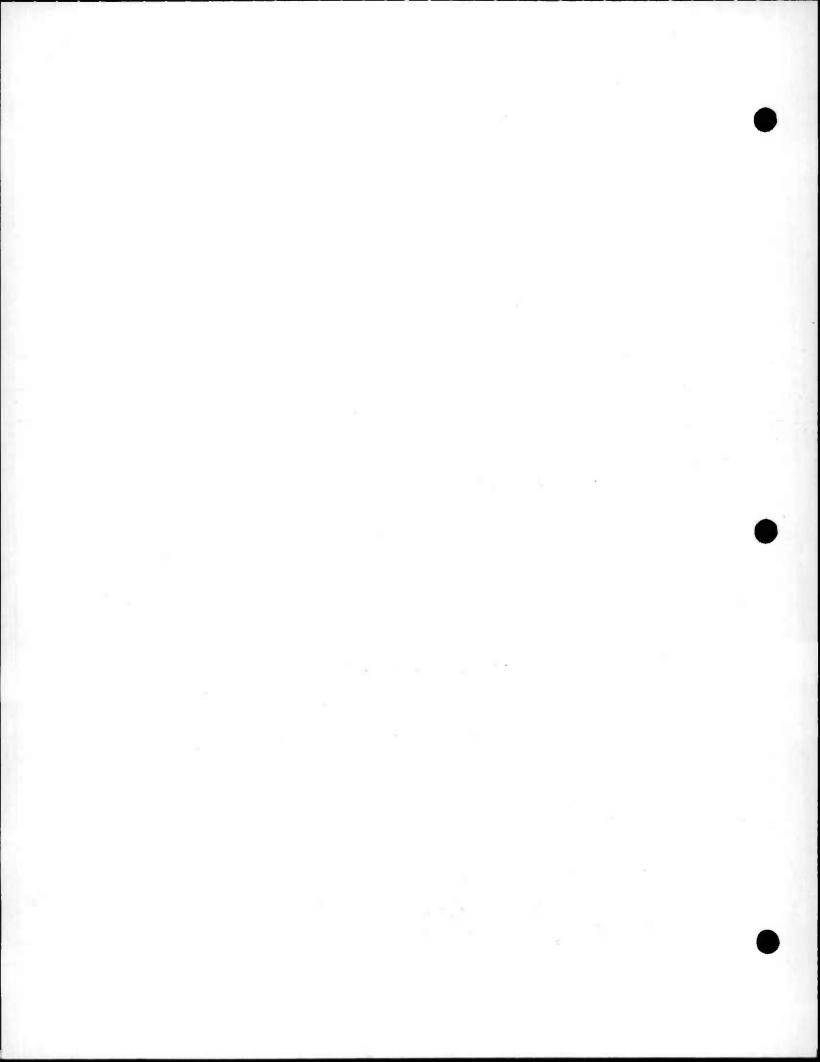
30. NAME AND ADDRESS OF PERSON WHAT IN WEST 31. DATE FILED 1008, 1995

										95		3964
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /				EALTH ANI	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)				TOAT	<u> </u>	DEATH	0.047	E OF DEATH			
	CHRISTOPHER WILSON F							MONT		¥	YEAR	3. TIME OF DEATH
								MAY	8, 1995			12:20 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)		ER 1 YEAR	IF UNDER 24 HR		OF BIRTH th, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
	229-46-2117	1 XX M 2 □ F	56	YRS.	MONTHS	DAYS	HOURS MIN		28, 1938		VIRG	
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CIT	Y, TOWN (OR LOCATION OF				NTY OF DEA	
0 8	13202 SANDSTON COURT	Г					LAUREL	1771			NCE GE	
[2]	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TV										
DIRECTOR		PRINCE GEOR	GE	10c, CIT	Y, TOWN	OR LOCAT	LAUREL					IOd. INSIDE CITY LIMITS? YES 211 NO
ايا	10e. STREET AND NUMBER					101	. ZIP CODE		-	10a CITI		707
FUNERAL	13202 SANDSTON COURT	r .					20708		USA			AT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13	. WAS DEC	ENDENT OF HIS	PANIC ORIGI	N? (Specify Yes	or No-	14. RACE -	- American Indien,
	1 Never Married 2 Married	IF YES, GIVE	YES 2 1	NO		If yes, sp	ecify Cuben, Max 2, NO Sp		Rican, etc.)		Black, Specify:	White, etc.
B	3 🗋 Widowed 4 🗌 Divorced	1958 - 1				. 🗇	2XX NO Sp	вопу.			Specify.	WHITE
	15. DECEDENT'S EDI	JCATION	16a, DE	CEDENT'S	USUAL	OCCUPATION	ON	161	b. KIND OF BUS	INESS/IND	USTRY	
E	(Specify only highest grad			ive kind of v	work done	during mo	st of working		or 10,110 or 200			
1 7		College (1-4 or 5	+)									
COMPLET	12	Ø		CLI	ERK					AIL		
8	17. FATHER'S NAME (First, Middle, Last)								Middle, Maiden			
m	SAMUEL JOHN PETRATOS	<u> </u>					CARRIE	ELIZABE	TH HOWAR	RD.		
8	19a. INFORMANT'S NAME (Type/Print)		190	b. MAILING	ADDRES	SS (Street a	and Number or Ru	ral Route Num	ber, City or Town	, State, Zip	Code)	
2	PATRICIA A. PETRATOS	S		13202	SAND	STON	COURT	LAUREL	MARYL	AND	2070	8
	20a, METHOD OF DISPOSITION		20b. PLACE					DAT			City or Town	
	1 Buriel 2xx Cremation 3 Ren 4 Donation 5 Other (Specific)	noval from State	cemetery, cre	matory or o	ther place	CTON	CREMATOR'	5/8				11,020
	21. SIGNATURE OF FUNERIAL SERVICE LI	Advecer	DALITM	IOICE WA	-				LAU	IKEL,	MARYLA	ND
	21. stumment of regional service to	In a	1		22	. NAME AN	ND ADDRESS OF	FACILITY	FLECK FU	INERAL	HOME,	INC.
	1 0/000	Vellers	Va,			760	1 SANDY	SPRING	POAD. I	AURFI	MD	20707
	23. PARTI. Enter the diseases, gr	Christiente the	et cultura the de	oth Do a					,		,	
1	shock, or heart failure.	List only one call	ree on each line),	ior aura	n the mo	de Di dying, a	uch aa çan	diec or respii	atory arr	est,	Approximate interval Between
	IMMEDIATE CAUSE (Final	/	1				*					Onset and Death
1 1	disease or condition resulting in death)		Cex	rent	tia	L W	14h 1	cent	al n	ency	les	
	1	DUE TO	(OR AS A CONSEC	DUENCE OF	F):	SU	green	Lui	500460	ein.	100	
z		b .				37	2 1000	<u> </u>	00		ucq	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE OF	ງ :							
I₹I	cause. Enter UNDERLYING											
표	CAUSE (Disease or Injury thet initiated events	DUE TO	(OR AS A CONSEC	QUENCE OF	7:							+
듩	reauiting in death) LAST				•							
岡		d										-
	PART ii. Other aignificant condition	na contributing to	deeth but not r	esulting i	n the u	nderiying	ceuse given	in Part I.	24a, WAS AN	AUTOPSY	24b. W	/ERE AUTOPSY FINDINGS
MEDICAL		Inmu		Lee	-	٥.			PERFOR		A	WAILABLE PRIOR TO
<u></u>		01001001	1 to 000			4			1 TYES 2	NO		OMPLETION OF CAUSE OF DEATH?
Σ											1	YES 2 NO
ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO Z	UNCERTA	AIN 🗆				
₹	25. WAS CASE REFERRED TO MEDICAL		26. PLAC	E OF DEAT	H (Check	only one)						
밀	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ 2004	OTHE							
ı ını	27. MANNER OF DEATH						e 5 🗆 Rasideno					
₹ ¥		26a. DATE OF (Month, D		28b. TIM	URY	28c. INJI WO	RK?	28d. DE:	SCRIBE HOW IN	JURY OCC	URED	
PHYSICIAN:	~ /				M	1 🗆 Y	rES 2 NO					
	1 Accident 5 Pending Investigation											
BY	5 Pending Investigation 3 Suicide 8 Could not be	28e. PLACE O	OF INJURY At horate, (Specify)	ma, farm, s	treal, lac	tory, office			CATION (Street at	nd Number	or Rural Rou	ite Number,
ED BY	1 Accident 5 Pending Investigation	28e. PLACE C building,	OF INJURY — At horatc. (Specify)	ma, farm, s	trani, inc	ctory, office			CATION (Street ar or Town, State)	nd Number	or Rural Rou	ite Number,
ED BY	1	building,	atc. (Specify)					City	or Town, State)			ite Number,
ED BY	1 Accident 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	ICIAN: To the best of	my knowledge, de	ath occurre	od at Ihe	lime, date	and place, end o	City	or Town, State)	ner es atate	rd.	
MPLETED BY	1 Accident 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	ICIAN: To the best of	my knowledge, de	ath occurre	od at Ihe	lime, date	and place, end o	City	or Town, State)	ner es atate	rd.	ite Number, nd manner as stated.
COMPLETED BY	1 Accident 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	ICIAN: To the best of a	my knowledge, de	ath occurre	od at Ihe	lime, date	and place, end o	City lue to the car he time, data	or Town, State)	ner es atate	ed. a cause(s) a	nd manner as stated.
MPLETED BY	1 detural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI	ICIAN: To the best of a	my knowledge, de	ath occurre	od at Ihe	lime, date	and place, end death occurred at t	City lue to the car he time, data	or Town, State) use(s) and manual and placa, and	ner es atate i due to Ihi 29d, DATE	ed. a cause(s) a	nd manner as stated.

DEATH (ITEM 27) (Type, Print)

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			1 - FOR STATE OF MARYLAND / DEPA CERTIF	RTMENT OF HEALTH AND	MENTAL HYGIEN REG. NO.		
			1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
			EDWARD 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)	TER SR.	MAY 1, 1	995	7:00 P.M.
-			215-01-8592 10 M 2 OF 78 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year)	Coun	HPLACE (State or Foreign try) RRYLAND
3 should		œ	9s. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DE TOWSON, MARYL	EATH	9c. COUNTY OF	DEATH
1, 2,		CTOR	RESIDENCE OF DECEDENT		AND	BALTIM	IORE .
Pages		DIRE		PARKVILLE			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
permit.		AL	10e. STREET AND NUMBER	10f. ZIP CODE	4		WHAT COUNTRY?
020 physician. burial-transit		FUNER	9622 1/2 HARDING AVE 11. MARITAL STATUS 12. WAS DECEDENT, EVER IN U.S. ARMED	21234	1	USA	
		BY FL	1 ☐ Never Married 2 Married FORCES? 1 YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS OECENDENT OF HISPAN If yes, specify Cuban, Mexica 1 YES 2 NO Specify	n, Puarto Rican, atc.)	Spe	E — American Indian, ck, White, atc. city:
			15. DECEOENT'S EDUCATION 18a. DECEOENT'	B USUAL OCCUPATION	16b. KIND OF BUS	SINESS/INOUSTRY	HITE
21 al or for u	- 1	ᇤ	(Specify only highest grade completed) (Give kind of life, Do NOT (life, Do NOT lif	work done during most of working use retired.)	Carpen	ter UN	1011
AND 2 he hospital detached to	once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	NTER THE MOTHER'S NA	ME (First, Middle, Maiden	cur 10	1
E 2 7	क	ш	HENRY H. RITTER	ALIC		ORGAL	4
retained 5 should	notified	TO B	190. INFORMANT'S NAME (Type/Print) ELIZABETH RITTER 96	G ADDRESS (Street and Number or Rural I 22 V2 HARDING			21234
may be	9		20s. METHOO OF DISPOSITION 20b. PLACE AND DATE	OF DISPOSITION (Name of	OATE 20c. LOC	CATION — City or T	
9 w 8	er must		1 during 2 Cremation 3 Removal from State Cametery, crematory or DULANE 2 21. SIGNATURE OF FUNERAL SERVICE LICENSE	22. NAME AND ADDRESS OF FA	5 5/5/95 TI	MONIUM	1. Md.
ALTIMOR death. Page 6 ma tuneral director, p	examiner		Xxxt(0)	EVANS Chapel	& Memor	ies 2-ltimor	M121234
after y the	or removal		23. PART i. Enter the diseases, or complications that caused the deeth. Do	not enter the mode of dyling, such	h as cardiec or reapi	ratory arreat,	Approximate
filled in b	on, or r		IMMEDIATE CAUSE (Finel				Interval Between Onset and Death
within pietely	l, cremati event, t		disease or condition resulting in deeth) RESPIRATORY INSUE DUE TO (OR AS A CONSEQUENCE OF				
executed and con	100	N	Sequentially list conditions, 6. MALIGNANCY NEOPLA		G		
S & E	traum	ATIC	if any, leeding to immediate cause. Enter UNDERLYING	OF):			
certificate ding physi	other	CERTIFICATION	CAUSE (Disease or injury that initiated eventa oue TO (OR AS A CONSEQUENCE (resulting in deeth) LAST	OF):			
eath atten	Mental Hy	CER	d				1
2 # £	= =	CAL	PART II. Other significent conditions contributing to deeth but not resulting	in the underlying cause given in	PERFOR	MED?	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
puires this signed	shows any	MEDICAL	HISTORY OF ASBESTOS EXPOSURE		X_ YES 2	□ NO	CDMPLETION OF CAUSE OF DEATH? YES 2 NO
L H law rec			DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y		v 🗆		12 12 1
E 9	State C	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 □ Nursing Home 8 □ Residence	Y	HACDIA	12
HYSICIA lis certi	흩	РНУ	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIM		28d. OESCRIBE HOW IN	HOSPIC	-
NING P	arked.	è	1 X Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, larm,	M 1 YES 2 NO	DOM A CONTION OF		
OR ATTENDING PHYSICIAN:	F		4 Homicide determined building, atc. (Specify)	street, factory, office	2at. LOCATION (Street a. Cify or Town, State)	nd Number or Hural	Houte Number,
AL OR		1	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurrence.				
HOSPIT	TANT	8	MEDICAL EXAMINER: On the basis of bigoffination end/or investigati	on, In my opinion, death occured at the			
TO THE HOSPITAL OF	MPOR	E	296. SIGNATURE OF SERTIFIER CHARGE	29c, LICENSE NUN	IBER	29d. OATE SIGNED	
F F.		٩	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type		24.7	5/2/9	
12	-		Samuel C. H. Lee, M.D., St. Joseph M 31. DATE FILED (Month, Day, Year) 32. REGISTRARY GIONTINE AAV 0 8 1005	edical Ctr., Tow	son, Md.	21204	
			MAY 0 8 1995 Julia Maridian Maridate				

020	ng physician.
BALTIMORE, MARYLAND 21215-0020	ge 6 may be retained by the hospital or attending
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE MOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Schours after death. Page 6 ma	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, p	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR RomE 4-27 9:50 Am " 95 JOSENH 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTN (Month, Day, Year) 6. BIRTNPLACE (State or Foreign MONTHS DAYS HOURS 1) M 2 F 284-10-6036 82 YRS. JUNE 2, 1912 CZECHOSLOVAKIA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH GOLDEN OAKS NURSING HOME DIRECTOR PRINCE GEORGE LAUREL RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND HOWARD LAUREL 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 9103 TYMAT COURT 20723 USA. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 7 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2) Merried Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe College (1-4 or 5+) 12 MINER MINING 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) CYRIH ROME HELEN PROSEK 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9103 TYMAT COURT, LAUREL, GERALD RUEHL MARYLAND 20723 20+. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 ☐ Buriel 北〇 Cremetion 3 ☐ Removal from State Completery, Cremetory or other place)

BALTIMORE WASHINGTON CREMATORY 4 Donetion 5 Other (Specify) 4/28 LAUREL, MARYLAND 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 21. SIGNATURE OF FUNERAL SERVICE LICEN 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 23. PART I. Enter the diseases, or leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximsta shock, or heart fully re. List only one car Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in deeth) Dis ease · (OYONAYY DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentisily list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY Chronic Dulmonn Obstructive Dry euse 1 TYES 2 7 NO Hypertensi 1 YES 2 NO Dementia PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Reeldence 6 Other (Specify) 27. MANNER OF DEATN 26e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town. State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER
(Check only one)

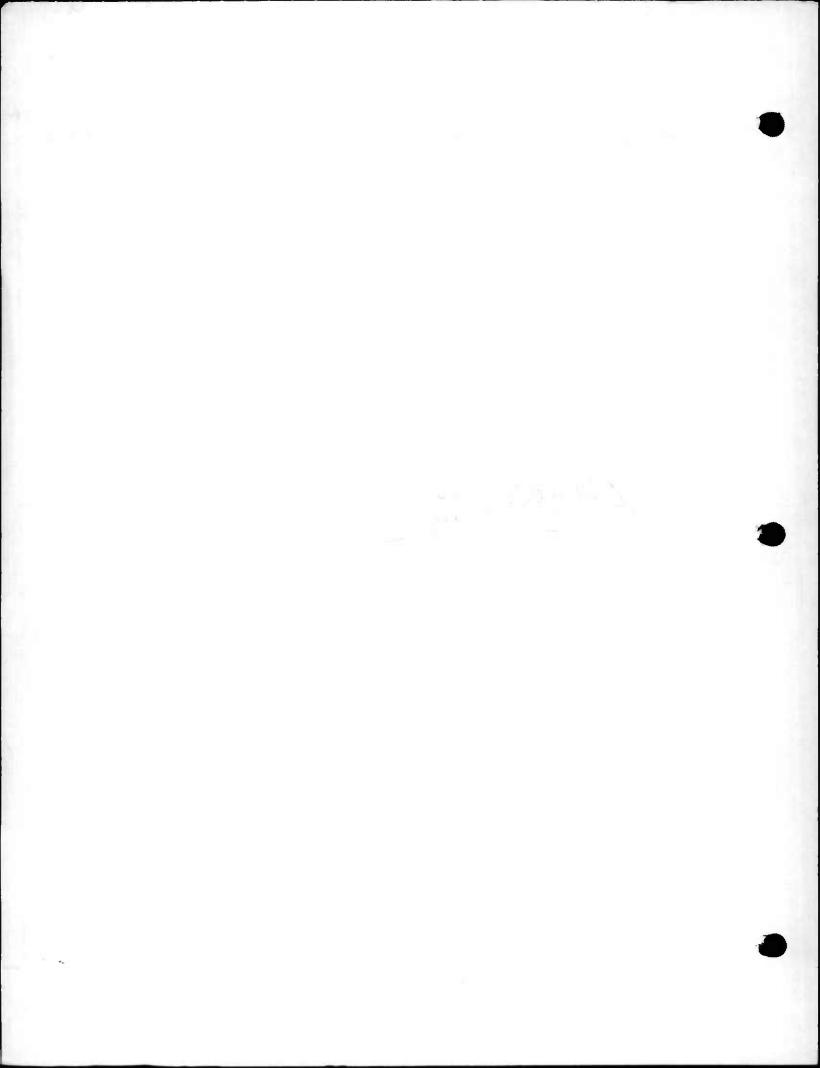
One)

MEDICAL EXAMINED. On the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated.

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H102 m 723181 -2-95 07 20 5

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

G. BHOJRAJ, MD 704 Gorman Asc # T-1 Laurel 2070



	-		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEF	PARTMEN	T OF H	EALTH AND	MENT	NL HYGIE REG. N				
		į	1. DECEDENT'S NAME (First, Middle, Lest)							E OF DEATH		3.	TIME OF DEATH	
		- 1		vin	RIC	HMOND			May		4, 199	5	12:45 p м	
		1	4. SOCIAL SECURITY NUMBER 233-14-2789	5. SEX 6. AGE	78 YR	MONTHS	R 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Moi	OF BIRTH		BIRTHPL.	ACE (State or Foreign	
pinc		1	9e. FACILITY NAME (If not institution, give		/O YR		70000			1.26,	- (1)	est	Virginia	
3 should	وا	<u> </u>	Franklin Squa		1	96. CIT		OR LOCATION OF D			9c. COUNT			
1, 2,	- 8	HOLO	RESIDENCE OF DECEDENT					.000111			Balti	more	County	
Pages		DINE	Md •	Baltimore	10c.	CITY, TOWN	OR LOCAT	Esse	v			10	d. INSIDE CITY LIMITS?	
permit. Pages 1,		AL D	10a. STREET AND NUMBER	Datcimore			L	I. ZIP CODE					YES MO	
£5			502 North Woo	ndward Driz	70		1 101		122	1	10g. CITIZE	USA	T COUNTRY?	
15-0020 ending physician, as the burial-transit		FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMEO	13.	WAS DEC	CENDENT OF HISPA			ee or No— 14	. RACE —	American Indian.	
a phy			1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			If yes, sp	ecify Cuben, Mexic	en, Puerto	Rican, atc.)		Black, W Specify:	fhite, etc.	
21215-0020 al or attending physician, for use as the burial-tran			16. DECEDENT'S EDU	ICATION .	T 44 . DESCRIPTION								White	
		EIED	(Specify only highest grade	College (1-4 or 5+)	16a. DECEDEN (Give kind life. Do NO	IT'S USUAL (I of work done)T use retired.)	during mo	DN est of working	16	b. KIND OF B	USINESS/INDUS	TRY		
	ءِ ار		12th	College (1-4 of 5+)	Ship	ping				Glen	L. M	arti	.n	
AND 21 the hospital or detached for u	once.	COMPL	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S N.	AME (First,	Middle, Mside	n Surneme)	*		
IARYL tained by should be	75		Alvin Wesley	y Richmond				Mint		Crook				
MARYLAND retained by the hospiting should be detached			ᅙ	190. INFORMANT'S NAME (Type/Print) Connie Reined	also	19b. MAIL	ING ADDRES	S (Street e	ond Number or Rural Mill	Route Nur	nber, City or To	wn, State, Zip Co	M A	21047
	å	ŀ	200. METHOD OF DISPOSITION		. PLACE AND DA									
BALTIMORE, er death. Page 6 may be the funeral director, page	examiner must		1 St Buriel 2 Cremation 3 Rem 4 Donation 8 Other (Specify)	noval from State Cen	netery, crematory	or other place		ery 5/	6 / Q		ocation — cir Baltii			
ALTIMO death. Page 6 funeral directo	in a	ı	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	Jak LA	22.	NAME AN	D ADDRESS OF F	ACILITY	7	Батст	HOLE	: Mu ·	
-	ехаш		+ R Tens	w/an	. 101	/		elly Fu						
aft v	medical	7	23. PART I. Enter the diseases, or	complications that caused	d the desth.	o pet ente	the mo	face Av	ch ss cs	Balti	more	Md.	21221 Approximate	
Though to	Ĕ		shock, or heart failure,	List only one cause on e	ach line.					0100	pinatory stress	••	interval Between Onset and Death	
ration and the	t, the		disease or condition	. Urosepsis									7000	
ted within completely fal. cremati	event,			DUE TO (OR AS A	CONSEQUENC	E OF):							4 days	
Secure Secure		Sequentially list conditions, OE Diabetes OUE TO (OR AS A CONSEQUENCE OF):										10 years		
Sea Pe	traumatic	₹	If sny, leeding to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSECUENC	E OF):								
	other		CAUSE (Disesse or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE	E OF):								
eath certification pattending patternding	5 B		reaulting in death) LAST	d										
Me de de			PART il. Other significent condition	ns contributing to death b	out not reaultin	ng in the u	nderivino	ceuse alven in	Part i.	24n WMS A	N ALITOPSY	24h WE	RE AUTOPSY FINDINGS	
C # P. S	> C	5							101	PERFORMED?		AVI	MILABLE PRIOR TO MPLETION OF CAUSE	
RECO requires the been signed	shows an									1 TES	2 3 0 NO		DEATH?	
_ ~ 0			DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH	YES 🗆	NO 🗵	UNCERTAI	N \square				_ 100 1 _ 110	
The The ate	ed, or Item 23 s		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D		. , ,							
CIAN:	1 10 X		1 TES 2 NO	1 🔀 Inpetient 2 🗆 ER/Outp	petient 3 🗆 DO	A 4 Nu		e 5 🗆 Residence	8 🗆 Oth	er (Specify)				
	24		27. MANNER OF DEATH 1 X Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF INJURY	_	RK?	28d. DE	SCRIBE HOW	INJURY OCCUP	ED		
ONING R		- 10	2 Accident Investigation	28e. PLACE OF INJURY	— At home, ter	m street too		ES 2 NO	201 1 01	2471041 (01				
TEN TOR:	28 ls		4 Homicide 8 Could not be	building, atc. (Spec	8e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)			City	or Town, Stets	end Number or)	Hunii Houte	Number,		
DIN A DIRECT DIRECT HOURS	ANT: If Item 28		29e. CERTIFIER 1 X CERTIFYING PHYSI	ICIAN: To the best of my knowl	ledge, death occ	urred at the	ime date	and place, and due	to the or	vec(a) and ma	anne en elete d		-	
HOSPITAL FUNERAL WITHIN 72 P	¥ N											euse(e) an	d menner es stated.	
TO THE HOSPITA TO THE FUNERA be filed within 7	F C											onth, Day, Year)		
O THE Se fied	2 E	.	1 gim (1	bon				D459-	9		15/	4/9	5	
	≥ P		30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (ype, Print)		, , ,			((-		
10			Karen Leber, M.D.	Deletimore, In 2125/					7					
7			MAY 0 8 1895	32 REGISTRAR'S IGN	ATURE						- 111 211			
		1	יין טכנסו טי וחווו		-									

The mark was to the same

BALTIMORE, MARYLAND 21215-0020

ITEMS: 4.6.7.8.15-18, PER F.H. FILM G-723 5/8/95 t t
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR CERTIFICATE OF DEATH REG. NO.

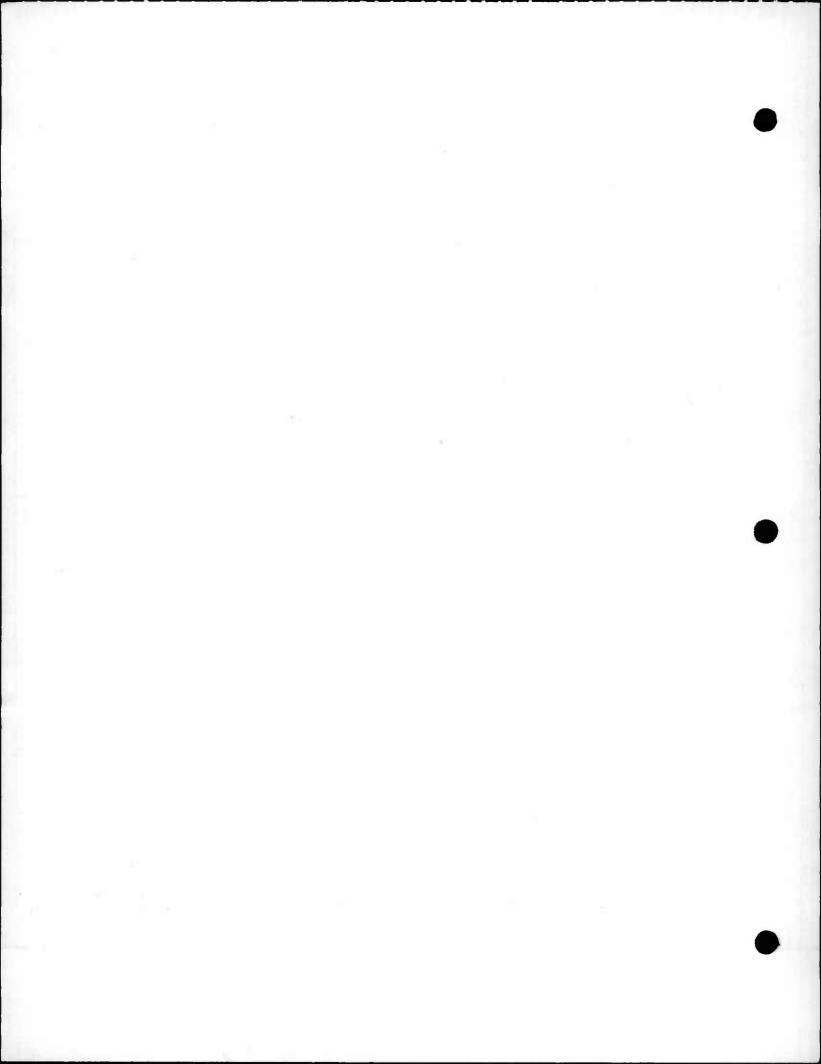
	1. DECEDENT'S NAME (First, Middia, Lost) JOAN ELIZABETH ROONEY SULLIVAN 2. DATE OF DEATH MAYTH4, 1995 YEAR 7/15									3. TIME OF DEATH				
	4. SOCIAL SECURITY NUM	BER	S. SEX 6. AGE (In yrs. last birthday)			IF UNDER	UNDER I YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH		8. BIRTI	HPLACE (Stetn or Popular)	
1 8	357-22-06	40	1 🗆 M 2 🏧 F	64	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)		Count	(ry)	
-	9e. FACILITY NAME (If not in		street and number)				9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH		
DIRECTOR	5137 Bonnie		ch Road			E1	lic	ott (City		Howard County			
1 5	10a. STATE	10b. COUNT				Y, TOWN					10d. INSIDE CITY			
	Maryland		ard County			Ellicott City					1 TES 2 NO			
FUNERAL	100. STREET AND NUMBER 5137 Bonnie		ch Road				101. ZIP CODE 21043				10g. CITIZEN OF WHAT COUNTRY? USA			
BY	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V		13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 Specify:				es or No-	e or No- 14. RACE - American Indian, Black, White, etc. Specify: White			
	15. DEC (Specify onl)	EDENT'S EDL y highest grade	CATION completed)	/G	CEDENT'S	work done	CCUPATIO	ON ost of working	а	166, KIND OF E	USINESS/IN	DUSTRY		
E	Elementary/Secondary (0	0-12)	College (1-4 or S	+) ///0.	Do NOT u	se retired.)			-	Ì				
COMPLETED	17. FATHER'S NAME (First, M	liddle Last)	4 years	3	HOM:	EMAK	ER	40 14077	AFFINO MAI		HOM	E		
		Calling	NIEL RO	ONEV						AE (First, Middle, Maid LIZABET		CEV		
TO BE	19a. INFORMANT'S NAME (7	lype/Print)		196	b. MAILING	ADDRES	S (Street o	nd Number	or Rural A	oute Number, City or To	wn, State, Z	ip Code)		
=	Mr. Peter L	. Sul!	Livan						h Ro	ad, Ellic	cott (City,	MD 21043	
	20e. METHOD OF DISPOSIT 1 □ Burlal □ 2 □ X rematic 4 □ Donation ◆ □ Other	n 3 🗆 Rem	noval from State	20b. PLACE	ND DATE	OF DISPOS	gtan	crema	tary	DATE 20c. 1	ocation –		own, State	
	21. SIGNATORE OF FUNERA	L SPHINCE LI	CENSEE	/			NAME AP	ND ADDRE	S OF FAC	HLITY			7	
	Mum	lall	a Je	ϵ	10053	35	Sla Ell	ack F Licot	uner t Ci	al Home, ty, Maryl	P.A. and 2	21043	3	
	23. PARY I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death)	eart falluje. 18i	List bnly bne cau	ise Dn each lina	•					l Cell			Approximats Interval Between Onaet and Death	
ATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or Injuthat Initiated events resulting in death) LAS	iry	c. DUE TO	(OR AS A CONSEC	DUENCE O	F):								
	PART II. Other algnifice	nt condition	na contributing to	deeth but not r	equiting	in the un	derlyler	2 001100 0	duen in E	Cont I as una	AL ALITONAL	Lau		
EDICAL				and the tree to	ooditiilig	ar the di	-conyma	a cansa é	nven in r	PERF	N AUTOPSY DRMED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MED										1 TYES	2 ND		DF DEATH?	
I - I	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO [UNC	ERTAIN	12			I I I I I I I I I I I I I I I I I I I	
CIA	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF DEAT	OTHER	-							
PHYSICIAN:	1 TYES 2 THO		1 🗆 Inpatient 2 🗆			4 🗆 Nun	sing Hom		_	Other (Specify)				
ву Рн		Pending Investigation	28e. DATE OF (Month, Da		28b. TIM INJ	E OF JURY M		URY AT RK? (ES 2 [28d. DESCRIBE HOW	INJURY OC	CURED		
8	3 Suicide 6	Could not be determined	28s. PLACE O building,	F INJURY — Al holetc. (Specify)	me, lerm, :	street, lact	ory, office			281. LOCATION (Stree City or Town, State	end Numbe	er or Rural Route Number,		
COMPLET	29e. CERTIFIER (Check only one) 2 DMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.													
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 5/5/95									(Month, Day, Year)				
10	30. NAME AND ADDRESS OF	PERSON WH	1065	Little	27) Type,	Print)	ul-	Ra	- Ku	vay) C	cue s.	- , (h.) .	
	MAY 0 8 1995 July 30 to the state of the sta													

State of the state

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

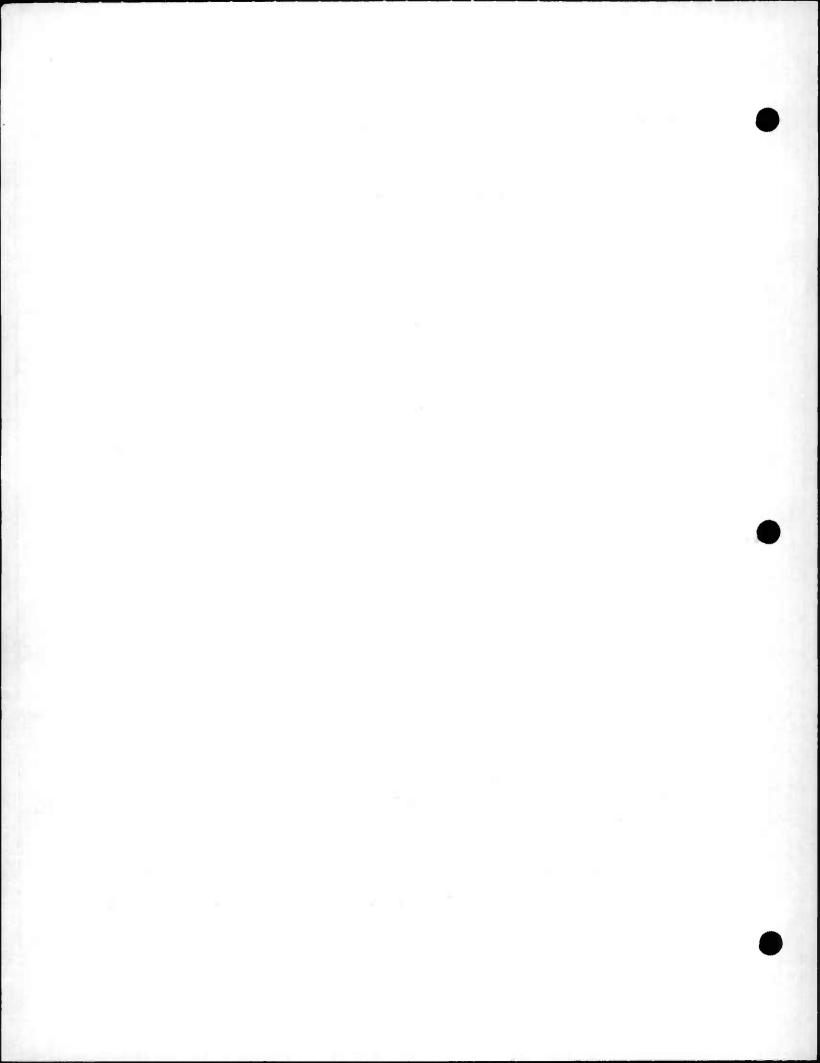
BALTIMORE, MARYLAND 21215-0020

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME			MENTA	REG. NO.	Ē		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATI	OF OEATH	Y Y	3.	TIME OF DEATH
,		Walter F.	Smith				Apr				1514 P M
Pi		4. SOCIAL SECURITY NUMBER 218-01-6243 A	5. SEX M 2 F 7 7	Inst birthday) IF UN YRS. MONTH	DER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH		Country	ACE (State or Foreign
2, 3 should	TOR	98. FACILITY NAME (If not institution, give str	Hospita	9b. C	ITY, TOWN 6	La It	ATN)		9c. COUNTY	OF DEAT	1 to
. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOW	B CL	ION +O					d. INSIDE CITY LIMITS? YES 2 NO
physician. burial-transit permit. Pages	FUNERAL	100. STREET AND NUMBER	Baltimo	re St	101.	ZIP CODE	23		10g. CITIZEN		T COUNTRY?
ling physician. the burial-tran	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	RMED NO		ENDENT OF HISPAN city Cuben, Mexica 2 NO Specify	n, Puerto		or No- 14.	RACE — Black, W Specify:	American Indien, hite, atc.
as	8	15. DECEDENT'S EDUC (Specify only highest grade of		DECEDENT'S USUAL (Give kind of work do	OCCUPATIO	N st of working	16	. KIND OF BUS	INESS/INDUS	rry	Diago IC
he hospital or att detached for use once.	WPLET	Elementary/Secondary (0-12)		ife. Do NOT use retire	teur	_	F	rould	lent	Sa	ving Bank
by the	BE COMPI	17, FATNER'S NAME (First, Middle, Last)	ith			16. MOTHER'S NA	ME (First,	Oin-	Surname)		
be retained ge 5 should e notified	10	190. INFORMANT'S NAME (Type/Pript)	th	19b. MAILING ADDR	ESS (Street ar	13a H	Noute Num	ster, City or Town	state, Zip Co	no,	1 21223
P 2 4		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)		EAND DATE OF DISE		me of	5/5	95 Cu	ATION - City	or Town,	State
ral direction		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		2 NAME AN	O DORESS OF FA	CILITY	1 1110	ct		
after death. Page 6 m by the funeral director, moval.		Blady	Ware		43	00 W	ak	sas L	Au	-	
urs in t		23. PART I. Enter the diseases, or co ahock, or heart fellure. L	implications that caused the district only one cause on each illustrations.	death. Do not en ne.	ler the mod	de of dying, auci	n as car	dlac or reapir	etory arreat	,	Approximate interval Between
File ion.		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Congestive	Heart Fa	ilure	•					Onset and Death 7 Years
P 2 - 9	Z	Sequentially list conditions,	Renal Failu								7Years
e be ex sician a prior to traum	CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONS	EOUENCE OF):							
th certificat ending phy il Hygiene p or other	ERTIFI	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE OF):							
the deat y the atte of Mental	0	PART ii. Other aignificant conditions	contributing to death but not	resulting in the	underlying	cause given in	Part i.	24a. WAS AN	UTOPSY	24b. WE	RE AUTOPSY FINDINGS
w requires that the been signed by tot, of Health and shows any Ir	MEDICAL	Hypertension, D	ilated Cardiom	yopathy			_	PERFORI 1 TYES 2		OF	MPLETION OF CAUSE DEATH?
× 2 2 2	N.	DID TOBACCO USE CONTR	BUTE TO CAUSE OF DE	ATH YES	NO 🗆	UNCERTAIN	· □			1 [YES 2 NO
the ste Th	PHYSICIAN:		26. PL HOSPITAL: IX Inpatient 2 ER/Oulpatient	ACE OF DEATN (Che	ER:	5 🗆 Rasidence		ar (Snacifu)			
PHYSICIA this certif with the rked, or	PHY	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	IRY AT		SCRIBE NOW IN	JURY OCCUR	ED	
DING PHYS After this of death with s marked	ВУ	1 Netural 5 Pending 2 Accident Investigation	= 0500	М	1 🗆 Y	ES 2 NO					
TTEN TOR: after	ETED	3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF INJURY — At a building, etc. (Specify)	home, farm, street, 1	actory, office			ATION (Street ar or Town, State)	nd Number or I	iural Route	Number,
7 72 =	COMPLET		AN: To the best of my knowledge, on the basis of examination end/o							iuse(a) and	d manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	A Fisher	w		29c. LICENSE NUM	BER /	7	29d. DATE SI	NED (Mo	nth, Day, Year)
	10	30. NAME AND ADDRESS OF PERSON WHO MICHAELL, FISHE	COMPLETED CAUSE OF DEATH (IT	EM 27 (Bups, Print)	1AXRYZ	AND H	WPI	AL E	Z S, C	REEN	VE ST. 11) 21201
\supset		MAY 0 8 1995	REGISTRAR'S SIGNATURE								,, –, –,



	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, La	JAS Jass	E KA	PETEL	ER.	2. DATE OF DEATH MONTH	1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 319 56 2749 9a. FACILITY NAME (If not Institution, gir	138 M 2 🗆 F 143	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	rso m	HRTHPLACE (State or Foreign country)
CTOR	4607 ARK	WOOD AV		BAL CITY, TOWN O	r LOCATION OF OR	атн Л	9c. COUNTY	A A
DIRE	106. STATE 106. COU	N/A	10c. CITY	TOWN OR LOCAT	ORL			10d. INSIDE CITY LIMITS? YES 2 NO
NERAL	100. STREET AND NUMBER 15 CT PARI	12. WAS DECEDENT EVER IN	rs.		212 COOE 21204	5	U	OF WHAT COUNTRY?
BY FUN	1 Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	FORCES? THEY YES	2 NO ATES	13. WAS DECI	cify Cuben, Maxica	IIC ORIGIN? (Specify Yan, Puarto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify:
PLETED	15. DECEDENT'S & (Specify only highest gr Elementery/Secondary (0-12)	DUCATION ade completed) College (1-4 or 5+)	16a. DECEDENT'S L (Give kind of wi life. Do NOT use	ork done during mos	N It of working	16b. KIND OF BU		
COM	17. FATHER'S NAME (First, Middle, Last)	50=02	<u> </u>	ER	16. MOTHER'S NA	ME (First, Middle, Maiden		1ARYLAND
TO BE	19a. INFORMANT'S NAME (Type/Print)	SPETALICE	19b. MAILING	ADDRESS (Street or	nd Number or Rural I	Route Number, City or Tox	rn, State, Zip Cod	21234
	20a. METHOO OF DISPOSITION Burlel 2 Cremation 3 R Donation 5 Other (Specify)	amoval from State	PLACE AND DATE OF	ner piacel	me of	OATE 20c. LC	CATION — City	or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			O HAR		FLOR	ers Ankville
ICATION	23. PART I. Enter the diseases, a shock, or heart failure immediate CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. DUE TO (OR AS A	ach lina.	otnc :			iratory arrest,	Approximate interval Batwean Queet and Daeth Months
CERTIFI	that initiated events resulting in death) LAST	d	CONSEQUENCE OF					
I: MEDICAL	PART II. Other significant condit	ions contributing to death b	ut not resulting in	the underlying	cause givan in	Part i. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
YSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetiant 2 ER/Outp	ettlant 3 🗆 DOA	OTHER:	ACE OF DEATH (Che	eck only one) 6 Other (Specify)		
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation		28b. TIME INJU	M 1 V	RK? ES 2 NO	26d. DESCRIBE HOW	NJURY OCCURE	D
	3 Suicida 6 Could not l	burning, atc. (Spec	-my)			28f. LOCATION (Street City or Town, State)		ural Route Number,
COMPLETED		YSICIAN: To the best of my knowl INER: On the basis of examination						use(e) end manner ee stated.
TO BE (29b. SIGNATURE AND TITLE OF CERTII 30. NAME AND ADDRESS OF PERSON	Ida H. So	~~~	Contact	29c. LICENSE NUN		29d. DATE SIG	NED (Month, Day, Year) 2.1,89,1995
	MATILDA 31. DATE FILED (Month, Day, Year)	H. Sp		144°	1 York	ROPD-	LUTH	EPOLE MOD
	MAY 0 8 1995 3	AZ REGISTRAR OSIGN	74.7					

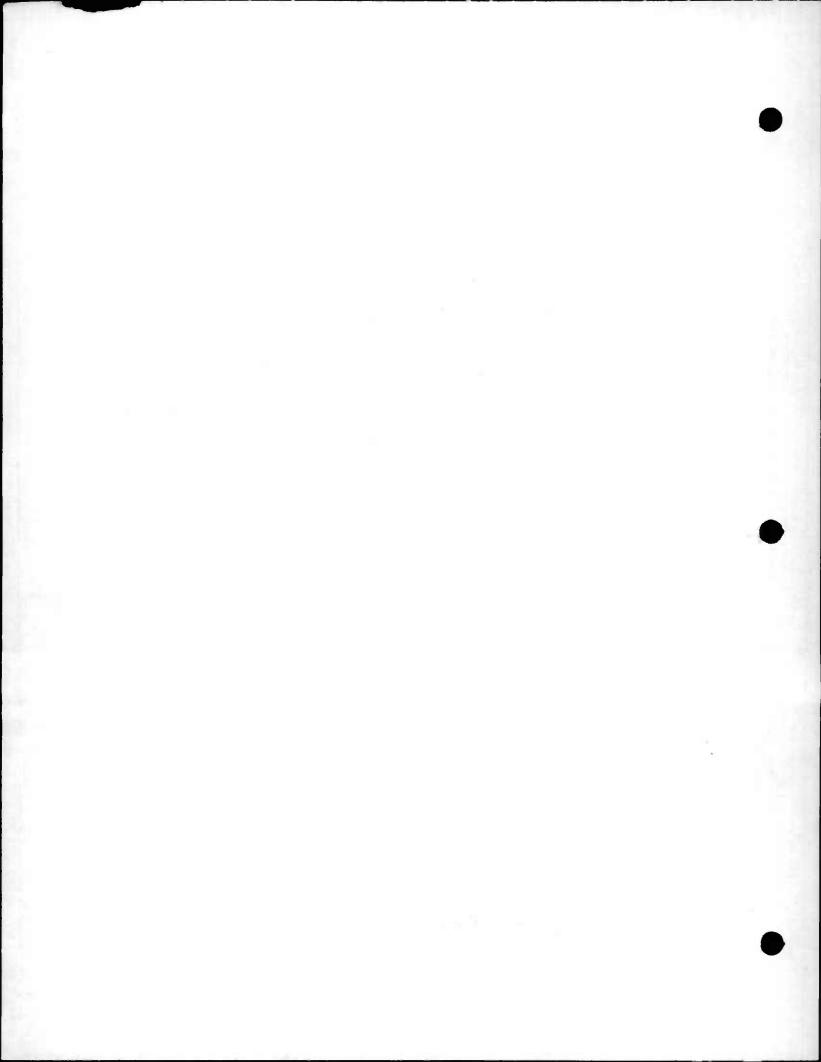
		FOR Item16a, Film72 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		MARYLANI	D / DEPAR CERTIF	RTMENT	OF H	HEALTH AND		HEG. NO	E		
			WRENCE			SEES	SE	SP	MO MA	Y 04	1995	YEAR	3:59A M
В		4. SOCIAL SECURITY NUMBER 220 66 0862	5. SEX 1 📉 M 2 🗆 F	6. AGE (In yrs	i. lest birthday) YRS.	IF UNDER		IF UNDER 24 HRS HOURS MIN.	. 7. DA	TE OF BIRTH onth, Day, Year) 26 58			LACE (State or Foreign
binous	~	9a. FACILITY NAME (If not institution, give	street and number)					OR LOCATION OF	DEATH		9c. COUN	TY OF DE	
1, 2, 3	СТОВ	BAYVIEW HOSPI	TAL.			Ba	alti	imore (City		N	/ <u>A</u>	
permit. Pages	DIRE		/A			y, town o Balti						- 1	Od. INSIDE CITY LIMITS? YES 2 \(\sum \) NO
	NERAL	6311 Hudson St						7. ZIP CODE 21224			10g. CITIZ		AT COUNTRY?
21215-0020 Il or attending physician. for use as the burial-transit	BY FUN	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		NT EVER IN U.S. I YES 2 MAR OR DATES	W NO	- 1	f yes, sp	ENDENT OF HISF ecify Cuban, Mex 2 RO Spe	ican, Puer	GIN? (Specify Yea to Rican, etc.)	or No-	14. RACE - Black, Specify: Whit	
D 21215 pital or attend ed for use as	PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5		DECEDENT'S (Give kind of life. Do NOT un	work done d se retired.)	luring mo	on ost of working .der		Fence C		USTRY	
YLAND 21 by the hospital or be detached for u at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) Richard E. See	ese				WEI	16. MOTHER'S		t, Middle, Maiden Gibson	Surname)		
MAR retained 5 should	TO B	19a. INFORMANT'S NAME (Type/Print) Deborah Fraska			196. MAILING	ADDRESS	(Street a	nd Number or Run Rd. Kin	il Route N	imber, City or Tow	n, State, Zip	Code)	
MORE, age 6 may be director, page		20a, METHOD OF DISPOSITION 1 Burlal 2X Cremation 3 Ren 4 Donalion 5 Other (Specify)	noval from Stata	cemetery,	CE AND DATE (, crematory or o	OF DISPOSI	ITION (Na	arme of		ATE 20c. LO	cation - o	Ity or Town	ı, Stata
SALT r death. F re funeral al.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE D. Gels	~		22. I Ch	name an	es S.Ze: Easter	iler	& Son	Inc.		
ely filled in station, or re		23. PART I. Enter the disease, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. GUNSH	ise on eech i	ilne.	not enter	the mo-	de of dying, au	ich ea c	erdiac or respi	ratory arre	est,	Approximeta interval Between Onaet and Death
executed n and com to burial, imatic ev	TION	Sequentielly list conditions, if any, leading to immediate	b	(OR AS A CON		,							
certificate of the part of the	RTIFICATION	ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. DUE TO	(OR AS A CON	SEQUENCE OF	F):							
2 8 8 5	L CE	PART II. Other algnificent condition	ne contributing to	deeth but no	ot resulting	n the unc	derivino	ceuse given i	n Part i	24a, WAS AN	ALITOREY	245 W	ERE AUTOPSY FINDINGS
L KECOKL law requires that th ss been signed by t ept. of Health and 23 shows any in	MEDICAL									PERFOR	MED?	C	MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 □ NO
	AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		EATH YE			UNCERTA	IN 🗆				
SICIAN: The certificate the State	PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER	1:	e 5 🗆 Rasidence	6 🗆 Ot	her (Specify)			
NG PHYSICIA fler this certi eath with the marked, or		27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, D	lay, Year)	26b. TIM	E OF URY	28c. INJU WO	URY AT	28d. D	EŞCRIBE HOW II		URED	
After the death	B	2 Accident Investigation		F INJURY - AL	022			ES 2 NO	+	BJECT S	SHOT	v Rumi Bou	to Alumbar
TTEN TTEN after after 28 L	ETED	4 Homicide determined	building,	of INJURY At etc. (Specify)	TREET				Ci	ry or Town, State) O ANG LE		BALTI	a Adam
보 보 가 만 보	COMPL		ER: On the best of ex										nd manner as stated.
TO THE HOSPIT TO THE FUNERS be filed within 7 IMPORTANT:	TO BE	BIS SIGNATURE AND TITLE OF CONTINUE	WA.	Not				O . C .					onth, Day, Year) 1, 1995
2		MARIO = GOLL	SJR W	D111 1	Penn ·		et,	Balti	imor	e, Mar	ylar	nd 2	1201.
		31. DATE FILED (Mobile, Day, Year) MAY () 8 1995	J2. REGISTRA	R'S SIGNATURI									



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
~ =	1	

	FOR 1 - STATE	STATE OF MA	ARYLAND /	DEPAR	TMENT OF	HEALTH AI	ND MEI	NTAL HYGIEN	E	0 1	4 7 7 7
(F)	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	James R			CATE O	DEATH	2. 1	REG. NO		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. lasi	Slav	•			fay 05	19	995	7:30 P.
7	234 22 1904	1 🔯 M 2 🗆 F	79	YRS.	IF UNDER 1 YEAR MONTHS DAYS	7	III.	DATE OF BIRTH (Month, Day, Year) Sept. 2, 1	1915	Country	PLACE (State or Foreign) DESSEE
~	9e. FACILITY NAME (If not institution, give s					OR LOCATION	OF DEATH		9c. COL	UNTY OF DE	ATH
2	740 Old Rivers	side Road			Baltin	ore			Anr	ne Arı	undel
DIRECTOR	10e. STATE 10b. COUNT	Υ		10c. CITY	, TOWN OR LOC	ATION					10d. INSIDE CITY
5	Maryland Ann	ne Arundel		Ba:	ltimore						LIMITS? 1 YES 2 NO
A	10e. STREET AND NUMBER				1	OI. ZIP CODE			10g. CIT		HAT COUNTRY?
삘	740 Old Riversi	de Road			_	21225	5		Ţ	J.S.A.	•
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT I	EVER IN U.S. ARI	MED	13, WAS DI	CENDENT OF H	ISPANIC O	RIGIN? (Specify Yes	or No-	14. RACE Black	- American Indian, White, etc.
à l	3 Wildowed 4 Divorced	IF YES, GIVE WAF	OR DATES			S 2 X NO		one mount ato.		Specify	y:
	15. DECEOENT'S EDU		16a. DE	CEDENT'S I	USUAL OCCUPAT	TON		16b. KIND OF BUS	INFES/IN	OHETRY	White
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ve kind of w Do NOT use	ork done during no retired.)	nost of working		IOU. KIND OF BUS	MAE 32/114	DOSTRY	
립	11th	0011090 (1-0 01 0 +)	E1	ectr:	ician			Genera	al Mo	otors	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER	'S NAME (F	First, Middle, Malden	Surneme)		
BE (P	laron Fran	klin Sl	.avy		1	Amand	la Cooper			
2	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING .	ADDRESS (Street	end Number or I	Rural Route	Number, City or Town	n, State, Zi	ip Code)	
-	Betty Slavy		74	40 01	d River	side R	oad	Baltimo	re, l	Maryl	and 21225
	20e. METHOD OF DISPOSITION 1 Burlal 2 □ Cremation 3 □ Rem	oval from State			F DISPOSITION (/					- City or Tow	
	4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	CHOPE	Md. S	tate	Vetera	ns Cem			wnsv	/ille	, Maryland
i	THE STATE OF YORKERSE SERVICE EX	C	1	,	Georg	e J. G	once	Funeral	Home	e P.A	•
	Jelone ;	mamico		1	4001	Ritchi	e Hwy	y. Balt	imor	e, Md	. 21225
	23. PART I. Entar tha diseases, of ahock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Meta Due TO (0	on each line.							rrest,	Approximeta Interval Between Onset and Daath
NO	Sequentially list conditions,	b	R AS A CONSEO								6 10000
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	c. DUE TO (O	R AS A CONSEO	UENCE OF)):		<u> </u>				
ᆼ	Dame II and a second										1
PHYSICIAN: MEDICAL	PART II. Other algnificant condition	e contributing to de	eath but not re	eauiting in	the underlyi	ng ceuse give	n in Part	I. 24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
											1 YES 2 NO
z	DID TOBACCO USE CONTI	RIBUTE TO CAU	SE OF DEAT	TH YES	ON [UNCER	TAIN [3		İ	
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			(Check only one OTHER:)					
ΥS	1 TYES 2 TO NO	HOSPITAL:			4 - Nursing Ho		nce 8 🗆	Other (Specify)			
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	280. DATE OF IN (Month, Day,	JURY Year)	26b. TIME INJU	RY W	JURY AT ORK? YES 2 N		. DESCRIBE HOW IN	JURY OC	CURED	
	3 Suicide 8 Could not be determined	28e. PLACE OF I building, atd	NJURY — At hor c. (Specify)	ne, ferm, st	reet, factory, offi	Ce	28f.	LOCATION (Street e City or Town, State)	nd Numbe	r or Rural Ro	rute Number,
COMPLETED		CIAN: To the best of my									and menner ea stated.
w II	296. SIGNATURE AND TITLE OF CERTIFIER	1		_		29c. LICENSE	NUMBER		29d. DAT	E SIGNED (Mogth, Day, Year)
∞	marka	my M.	り,			D30	750	5		5/7	195
٥	30. NAME AND ADDRESS OF PERSON WHO YUDHISHTEA		OF DEATH (ITEM		720	Cras	200	funy of	120	04.	MD 2/06/
	MAY 0 8 1995	RE HISTRA	SIG ATURE				4 20	15	w	m, c,	, ND 2106



DIVISION OF VITAL RECORDS, P.O. BOX 68760

MAY 0 8 1995

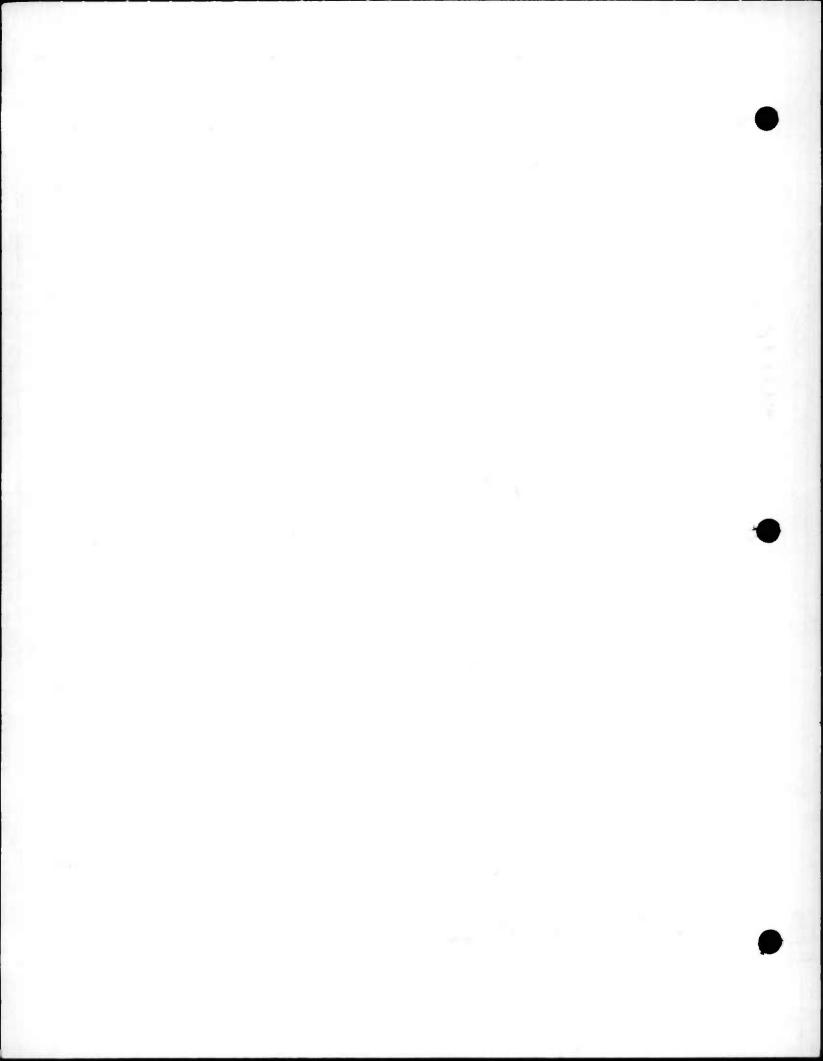
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or flows after death. Page 6 may be retained by the hospital or attending physician.

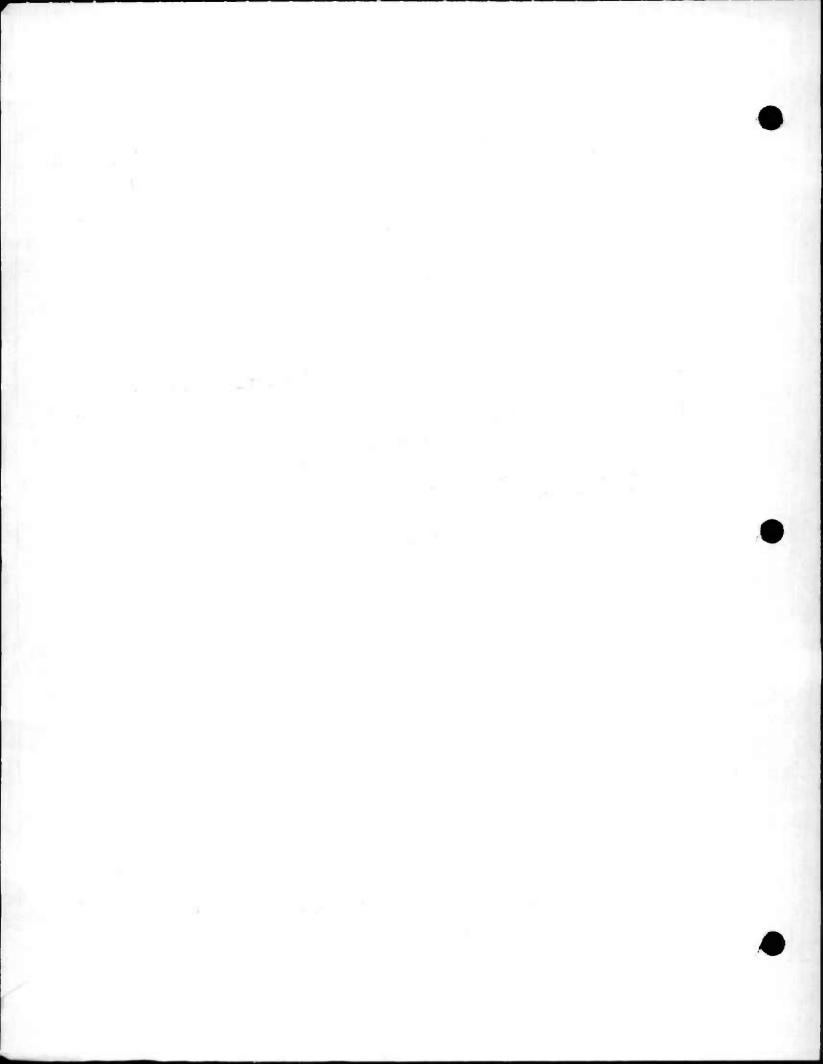
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	ITEMS: 9a,10c,10e,10f	,15,16a,17,	,18, PER	INFORM	ANT FILM	G-731 1/1	9/96	t.t		9	0	139/3
	FOR 1 - STATE REGISTRAR	STATE OF N			TMENT OF	HEALTH ANI DEATH	MEN		GIENE G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DE	ATH DAY		YEAR 3.	TIME OF DEATH
	Ingebora		S	trausb	augh			u 3.	1995		/EAH	6:25A M
	4. SOCIAL SECURITY NUMBER	s. SEX		. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	s. 7. D	ATE OF BIR	TH		BIRTHPL	ACE (State or Foreign
	220-74-7065	1 □ M 2 🂢 F	56	YAS.	MONTHS DAYS	HOURS MIN	Jä	Month, Day,	3,19	39	Gerimo	any
OR	Doctor's Hospital	OH YTINUMMO	SPITAL	-		on Location of anham	DEATH			9c. COUNT		H George
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,										
DIRECTOR	Maryland Pri	nce Geor	ge	10c, C11	Y, TOWN OR LOC	iverdal	e	NEW CA	RROLL	TON		d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER 7605 Riverdale Ro	ad #331	- APT. 4	02	1	of. ZIP CODE -207	37 2	20784		-		T COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN			13. WAS DE	CENDENT OF HIS	PANIC OF	RIGIN? (Spec	cify Yea o	r No — 14	. RACE -	American Indian,
BY	1 Never Married 2 Married 3 Wildowed 4 X Divorced	FORCES? 1 IF YES, GIVE W		MNO		pecify Cuban, Max S 2 X NO Spo		erto Ricen, e	rtc.)		Black, W Specify:	White
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a.	DECEDENT'S	USUAL OCCUPAT work done during n se retired.)	ION ost of working		16b. KIND (OF BUSIN	ESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 + 3		ailor	ANO HOU				Cl o	othin	a	
O	17. FATHER'S NAME (First, Middle, Last)	JUSTUS AUB					NAME F	FRMINE				. nee PRIESTE
	Justus Strausbaug	1-				Herm	ine	Prices	te			
BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Street	and Number or Ru	ral Route I	Number City	or Town	State Zin Co	orfs)	
임	Andree L. Strausb	augh		313 0	akmanor	Drive	#103	, Gle	en Bi	urnie	, MD	21061
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremellon 3 Rame		20b. PLA	CE AND DATE	OF DISPOSITION (ame of		DATE 2	Oc. LOCA	TION — CIt	y or Town,	Stata
	4 Donation 5 Other (Specify)	Ival from State	- Balt	AMO/LO.	Washina	ton Cre	$m \mid 5$	14 1	auro	ol. M	anis	and
1	21, SIONATURE OF FUNERAL SERVICE LIC	ENSEE)	22. NAME	ND ADDRESS OF	FACILITY					ome, Inc.
	> 1 20a0	Delk	rall	Se la la la la la la la la la la la la la	760	1 Sandy	Spr	ing R	Road,	, Lau	rel.	MD 20707
	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications that	caused the	death. Do r	ot enter the m	ode of dying, a	uch aa	cardisc or	reapira	tory arres	t,	Approximata
	IMMEDIATE CAUSE (Final	LIST ONLY DITE COL	Se OIL PRICE I	Ma							1	Interval Between Onset and Death
	disease or condition resulting in death)	. Metaste	atic A	denoca	rainoma	to Live	2 H.					
					N							
Z	Commentally, list any distance of	Adenoc	arcino	ma								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CON	SEQUENCE OF	7:							
2	CAUSE (Disease or injury	h										
E	that initiated events resulting in death) LAST	DUE TO	(OR AS A CON	SEOUENCE OF	j:							
H H	resoluting in dealth) Exist	l										
, II	PART II. Other aignificent condition	s contributing to	death but no	ot resulting	n the underlying	a ceuse aiven	in Part	1 24a W	AS AN AU	TOPSV	24b WE	RE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Coagulopathy	-							ERFORME		AVA	MILABLE PRIOR TO MPLETION OF CAUSE
								1 🗆 Y	YES 2 💢	S NO		DEATH?
Σ	DID TOPACCO LISE CONTE	NEUTE TO CA	LICE OF D	FATIL ME	с П но Г	T III MEED TA		,			10	YES 2 XNO
AN	DID TOBACCO USE CONTR	IBUTE TO CA					AIN L	1			<u></u>	
ᅙ	EXAMINER?	HOSPITAL:			H (Check only one OTHER:			_				
ΣŁ	1 YES 2 T-NO 27. MANNER OF DEATH	1 X Inpetient 2				ne 5 🗆 Raaideno	_		-			
	11/2 Natural 5 Pending	28a. DATE OF (Month, Da		28b. TIM INJ	URY W	JURY AT DRK?	28d.	DESCRIBE I	ILMI WOH	URY OCCUP	1ED	
B	2 Accident Investigation	20 81 100 5	Tuvura.			YES 2 NO						
COMPLETED	3 Suicide 8 Could not be 4 Homicide datarmined	building,	etc. (Specify)	homa, farm, s	tree1, factory, offi	CA .	281.	LOCATION (S City or Town,	Street and State)	Number or	Rural Route	(Number,
LE I	280. CERTIFIER 1 (Check guy) 1 (Check guy)	CIAN: To the best of	my knowledge	death occurre	ed at the time, dat	and plans and d	un de de		4		_	
AM I	2 MEDICAL EXAMINE	R: On the basis of as	amination and	for Investigation	n, in my opinion,	leath occured at 1	he time, :	data and pla	nd manne	r an atated. Sua to the c	ause(a) an	d manner as stated.
	296. SIGNATURE AND TITLE OF CENTIFIER		_			29c, LICENSE N						
TO BE	IN IX	hus			<	1032	20	1	2	▶ S	- 3	onth, Day, Year)
F	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (TEM 27) (Type	erine) Dol d	WI IAM	16-	2	14	مار د		
- 1	II vermo	1 Wales	-	- ~/)	12 - 1	1777777	- 49	, ,	-	Nem	~ ~ (~



		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART			MENTA	L HYGIEI				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	MY Y	EAR 3.	TIME OF OE	EATN
		LORETTA			OHT	MAS	MA		1995		3:23	РМ
should		4. SOCIAL SECURITY NUMBER 220-20-3396 90. FACILITY NAME (If not Institution, give str	1 - M 2 1 6	7 YRS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Ma	OF BIRTH	928 N	Jar	YAN	Foreign
. 2. 3	стов	1919 RIDGEHILI			BALTI	OR LOCATION OF D	EATN		9c. COUNTY	OF DEAT	M	
permit. Pages	DIRE	Maryland 10b. COUNTY	NA	Ba	H M	ore				- 1	d. INSIDE CI LIMITS? VES 2 [
. Jist	FUNERAL	1919 Ridgehi	11 Ave			21217	7		1 1	OF WHA	T COUNTRY	7
21215-0020 al or attending physician. for use as the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 M Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES :	2 PNO	II yes, sp	ENDENT OF HISPA ocity Cultur, Mexico 2 NO Specia	in, Puerto I	17 (Specify Ye Rican, etc.)	s or No— 14.	RACE — Bleck, W Specify:	American In Phite, etc.	ndlen,
1215-0 r attending use as the	E	15. DECEDENT'S EOUC (Specify only highest grade of		Sa. DECEOENT'S US	BUAL OCCUPATION MO	ON et of working	16b	KIND OF BU	ISINESS/INDUS	TRY	2191	~ \
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Home	etired.)	er		Owr	He	me	2	
/LA yy the be de	BE CO	Bernard V	Vard			18, MOTHER'S NA	HE (First, I	Middle, Maider	Vara			
	٩	Michael Ri	vers.	196. MAILING AI	DORESS (Street	nd Number of Rugal	Route Num	City or To	vn, State, Zip Co	Mc	1,21	217
e 6 m		20a. METNOD OF DISPOSITION 1 Metall 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State cemeter	ry, develop or other		me of	5/11/	95 LO	NS O	or Town,	State 1e, M	Nd.
ALT death. e funera e.		21. BIOMATURE OF FUNERAL SERVICE LICE	L. Ru	35	Jose 22. NAME AN Jose	D ADDRESS OF FA	RUS	SS F	uner	al Ita	Hom	2).17 11.
S = 5		23. PART L. Enter the diseases, or co shock, or heart failure. L	omplications that caused the	na daath. Do not	enter tha mo	de of dying, suc	h as cere	llec or resp	iratory arrest		Approxi	mats Batween
ofthin 24 Herely fille remation.		IMMEDIATE CAUSE (Final	pertensive A	Arterio	sclero	otic Ca	rdic	vasc	ular I	Dise	Onset a	and Death
2 a b b a	NO	Sequentielly list conditions,										
raur to the	CATIC	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CO	ONSEQUENCE OF):								
P.O. th certific ending pl Hygiene or othe	ERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):								
the death y the attend Mental Hinjury, or	O	PART II. Other eignificent conditions	contributing to death but	not reculting in	the underlying	cause given in	Part I	24s. WAS AN	Alimopey	245 WE	RE AUTOPSY	ENDINGS
K 50 5 >	MEDICAL							PERFO	RMED?	CO	AILABLE PRIO IMPLETION OF OEATH?	OR TO
	N: ME	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF I	DEATH YES	□ NO □	UNCERTAI	N []	INSP	ECTED	1[YES 2X) NO
ITAL N: The lav icate has State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. HOSPITAL:	PLACE OF OEATH	(Check only one)							
CIAN: The ertificate the State	IXSI		1 Inpatient 2 ER/Outpatie	nt 3 DOA 4	☐ Nursing Nom	5 X Residence	6 🗆 Other	(Specify)				
ON OF DING PHYSIC After this ce death with th	ву РНУ	XXNetural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y WO	JRY AT RK? ES 2 NO	28d, OES	CRIBE NOW	INJURY OCCUR	ED .		
TENDI TOR: A affer d	9	3 Suicide 8 Could not be determined	26e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, etre	et, lectory, office	×10		ATION (Street or Town, State	end Number or F	tural Route	Number,	
로 내 오 =	COMPLET		IAN: To the best of my knowledg : On the basis of examination en							use(e) en	d manner ee	stated.
E HOS With Myth	E C	29b. SIGNATURE AND TITLE OF CERTIFIER	\			29c. LICENSE NUI			29d. DATE SI			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	TO BE	Monald & U 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (5mg)	(nt)	0.C.			MAY			*
4		DONALD G. WRIG		1 Penn	•	et. Bal	timo	re.	Marvla	han	2120	1
_ '		MAY 0 8 1995	32 REGISTRAR'S SIGNATU	RE								



2, 3 st	2	5	GREATER BALTI	MORE MEDIC	CAL CENTE	R	TOWSON		BAL	TIMORE
les 1,	activa and a		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	ION			10d. INSIDE
permit. Pages	2	5	MARYLAND BOY	Spanill	7	Jank	100			LIMITS
permi		1	10e. STREET AND NUMBER	0		101	. ZIP CODE		10g. CITIZE	EN OF WHAT COUNT
Sit	LINEDA		814 Monkio	1 KORO			21111		1	.A.2.(
20 rysicia urfal-tr	1	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANIC	ORIGIN? (Specify Ye	s or No- 1	4. RACE — American Black, While, atc.
9 g a	2		3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES	2 NO Specify:			Specify
1215 r attend use as	ETEN		15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S USU (Give kind of work	AL OCCUPATION	ON .	16b. KIND OF BU	JSINESS/INDU	STRY
21 al or for u	[Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use ret	ired.)	st or wonang			
AND he hospit detached	once.	-	17. FATHER'S NAME (First, Middle, Last)		CARIT	JIER		Cor	WIRU	2012
YLA by the		- 11	GEORGE ROGS	RT TROX	(-)		18. MOTHER'S NAM	E (First, Middle, Maide	Sumame)	0.0.00
E 8 30	B 0	1	19e. INFORMANT'S NAME (Type/Print)	NON THON		RESS (Street a	nd Number or Rural Ro	ude Number City or To	LAH I	BRCER
5 50	1 2	2	DORIS TROYE		814 De	ockia	Rosa	Chaki	70	18V/200
m > g	st pe		20a, METHOD OF DISPOSITION Burlal 2 Cremation 3 Remo		PLACE AND DATE OF DI		1	DATE 20c. L	DCATION - CI	ty or Town, State
Page 6 m	T must		4 Donalion 5 Other (Specify)		etery, crematory or other p		smorial	83-1	monic	BAC DAR
- 0	examiner	1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FACE	JIH2 30	ک	
			KIND AKNO	mal		2322	YORK	000-1	iman.	um
\$ ≥ 8	medical	T	23. PART I. Enter the diseases, or c	omplications that caused list only one ceuse on e	tha death. Do not e	entar the mo	da of dying, such	an cerdlec or resp	iratory arras	it, Appro
2 g 2			IMMEDIATE CAUSE (Final	clar only one cedse on e	ech line.	/	1 11	1		Interv Onset
il il il il il il il il il il il il il i			disease or condition resulting in death)	Jen	trula	0/10	brille	un.		1/
	6			DUE TO LOR AS A	CONSEQUENCE OF):	000	1.7	1	1	1/2
68 Baccu	traumatic		Sequantially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF:	joean	and 1	mpare	con	1-0
S E E	tra L		if any, leading to immediate cause. Enter UNDERLYING	A	SCVD	0	Corona	in arte	en de	close 40
	other L		CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			1)	0
0	5 4		resulting in death) LAST	l						
DS the d	-	- 19	PART il. Other significant conditions	contributing to death b	ut not resulting in th	e undarlying	cause givan in P	art I. 24a. WAS AI		24b. WERE AUTOR
CORI								PERFO		AVAILABLE P
RECO requires the sen signed of Health	shows									OF DEATH?
AL RE e law requente bas been of the officers			DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YES		UNCERTAIN			
一年 章章			25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (C	heck only one) HER:				
CIA Sertif	1 SX		1 VES 2 NO	1 Inpatient 2 ER/Outp		Nursing Home	5 Residence 6			
O PHY Stiff	본 .		1 Natural 5 Pending	(Month, Day, Year)	INJURY	28c. INJU		8d. DEŞCRIBE HOW	NJURY OCCU	RED
0	= =		2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	- At home, lerm, street			81. LOCATION (Street	and Number or	Rural Route Number
EA	ETEO ETEO	1	4 Homicide determined	building, etc. (Spec	ify)	ALCOHOL MICHAEL		City or Town, Stete	1	That are the traces,
8 8 8			29a. CERTIFIER 1 CERTIFYING PHYSIC	SAN: To the best of my knowl	edge, death occurred at	the lime, data	and place, and due to	the cause(s) and me	oner en steled	
SPIT	COMPLE			t: On the basis of examination						
TO THE HOSPI TO THE FUNER TO Filed within	PORTANT BE CO		296. SIGNATORE AND TITLE OF CERTIFIER		1 -		29c. LICENSE NUMB			Day.
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	TO BE	- 16	Machole	opean 1	ND :		P19	155	▶ ₹	12/9
,	٦		MARKS, KAPI	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Print	11.01	· V2 1	1000		11/1
10		L	DATE EN ED MOSTO	HN WIN.	1074	40 RIC	- Kd.	NONCT	5W V	Md Z
	- 1	11 3	B1. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE					

Juli Shudson Reveal

TROXEL

6. AGE (In yrs. lest birthday)

5. SEX

1'M M 2 | F

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

229 01 4312

MAY 0 8 1995

KYLE DRAPER

9e. FACILITY NAME (If not institution, give street and number)

1

ges 1, 2, 3 should

95 13975

8. BIRTHPLACE (State or Foreign Country)
VIRE: NA

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11116

JARYLAGO

Approximete Interval Batween Onset and Daath

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 - NO

Dev. Year)

end due to the ceuse(s) end manner es stated

3. TIME OF DEATH

9:02

10d. INSIDE CITY LIMITS? 1 YES 20 NO

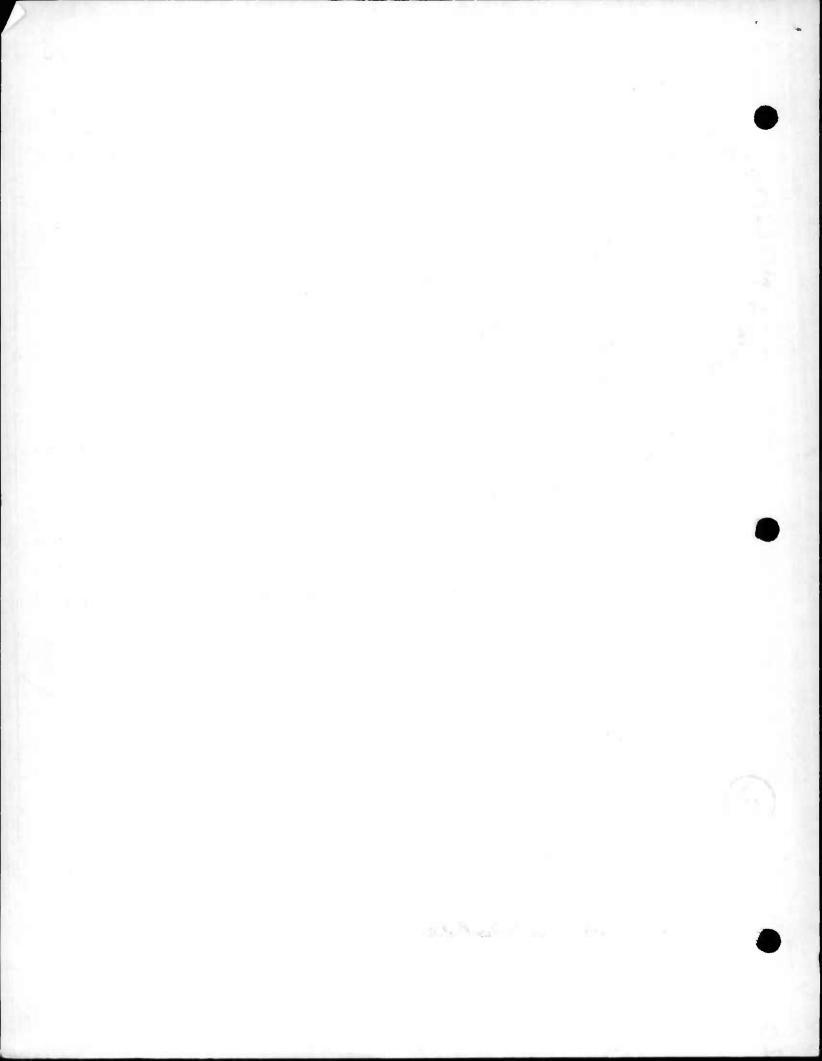
14. RACE — American Indian, Black, While, atc.

2. DATE OF DEATH

1995

May 1.

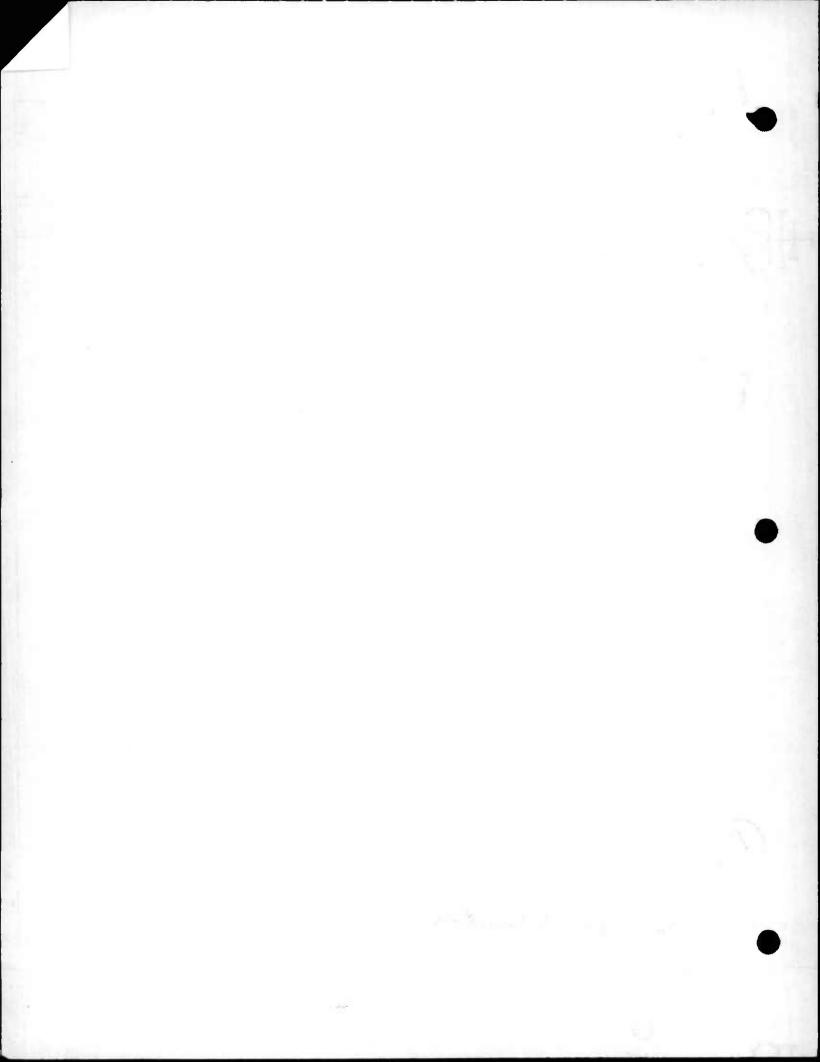
7. DATE OF BIRTH
(Month, Day, Year)
APRIL 7



FOR STATE REGISTRAR

4 DECEDENTIO NAME (Class Address Asset)							1		
1. DECEDENT'S NAME (First, Middle, Last)	T37						2. DATE OF DEATH		3. TIME OF DEATH
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	100	1	YRS.		-	HOURS MIN.	(Month, Day, Year)	10271	BIRTHPLACE (State or Foreign Country)
		-01		9h CITY T	DWN O	OR LOCATION OF O			ANAIDH
		Cento	_	-			CATT		
RESIDENCE OF DECEDENT						V. I. C. L.		CE	CIL
									10d. INSIDE CITY LIMITS?
	AI TOT O		A	BING	-				1 YES 2 NO
	· M	1-			10f.	ZIP CODE	00	10g. CITIZEN	OF WHAT COUNTRY?
			WED	40 1111		410	09		USA
1 Never Married 2 Married	FORCES? 1	YES 2 1		lf y	yes, spe	ecify Cuban, Maxic	en, Puarto Rican, atc.)	or No — 14.	RACE — American Indian, Black, Whita, atc.
3 Widowed 4 Divorced				''	_ TES	2 JA NO Speci	у:		Specify: WHITE
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)						16b. KIND OF BU	SINESS/INDUS	
Elementary/Secondary (0-12)	4) life	. Do NOT us	e retired.)		-	1100 0		
	4	De	tens	e IN	SPE				ment
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		1 10		4000000000					RKINS
	REY								
20a. METHOD OF DISPOSITION		20h BLACE	ANDDATEC	AF OICDOORTI	ON W				
1 1 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from Stata	cemetery, cre	matory or of	ther place)	M	RIA		the state of the state of	A A .
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	A		22. NA	ME AN	D ADDRESS OF FA	CILITY	- C	1110
gobertas	Lylowe	all I		EVA	508 508	s Chaper OHarford	a Rd. Ball	O.Md	21234
shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Pneumo	nia) .		не moc	ae or aying, suc	n as cardiac or respi	ratory arrest	, Approximate interval Between Onset and Deati
_									
Sequentially list conditions, if any, leading to immediate									
CAUSE (Disease or injury	c	OR AS A CONSE	OUENCE OF	a.					
resulting in death) LAST		,	JOENIOE OF	,.					İ
	d								
			esulting i	n the unde	rlying	cause given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE
								41,110	DF DEATH? 1 ☐ YES 2 📉 NO
DID TOBACCO USE CONT	RIBUTE TO CAL	USE OF DEA	TH YE	S IN	ο□	UNCERTAIL	V 🗆		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT		y one)				
1 TYES 2 NO		ER/Outpatiant 3	□ DOA		g Home	5 🗆 Rasidenca	8 Other (Specify)		
			28b. TIME	E OF 28 URY	C. INJU	JRY AT	26d. DESCRIBE HOW I	NJURY DCCUR	EO
2 Accident Investigation									
3 Suicide 6 Could not be determined	28a. PLACE OF building, a	FINJURY — At ho inc. (Specify)	me, farm, s	traat, factory,	, offica		281. LOCATION (Street a City or Town, State)	nd Number or F	tural Route Number,
29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of s	my knowledga, de amination and/or i	ath occurre	d at the time	, data a	and place, and due	to the cause(a) and mer time, data and place, an	ner as stated.	use(a) and menner as stated.
one) 2 MEDICAL EXAMINE	- OII the basis of ax								
2 MEDICAL EXAMINE						29c. LICENSE NUI	ABER .	29d. DATE SIG	GNED (Month, Day, Year)
2 MEDICAL EXAMINE						29c. LICENSE NUI D32395			GNED (Month, Day, Year) 29–95
2 MEDICAL EXAMINE 299. SIGNATURE AND TITLE OF SERTIFIE 30. NAME AND ADDRESS OF PERSON MA	O COMPLÉTEO CAUS	E OF DEATH (ITE				D32395			
2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON ME THOMAS FINUCAN,	O COMPLÉTEO CAUS	E OF DEATH (ITEI VAMC , PE			, мі	D32395			
	4. SOCIAL SECURITY NUMBER 317-16-1965 9a. FACILITY NAME (If not institution, give) PECTY POINT RESIDENCE OF DECEDENT 10a. STATE 10a. STATE 10a. STATE 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDIC (Specify only highest grade) Elementary/Secondary [0-12) 17. FATHER'S NAME (First, Middle, Lest) 19a. INFORMANT'S NAME (Type/Print) 19a. INFORMANT'S NAME (Type/Print) 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ram 1 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) Sequentially in death) LAST PART II. Other significant condition COYONARY ATTE DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending Investigation 3 Suicide S Could not be	317-16-1965 9a. FACILITY NAME (if not institution, give street and number) Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Point Medical Perry Perry Point Medical Perry Perry Point Medical Perry	4. SOCIAL SECURITY NUMBER 317-16-1965 9a. FACILITY NAME (if not institution, give street and number) PCTY POINT MEDICAL Cente RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY HOTOR 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AFFORCES? 1 YES 2 IF YES, CIVE WAR OR DATES 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary [0-12) 20a. METHOD OF DISPOSITION 1 MEDICAL Center 15. 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Signe And Consequence of Completed (Consequence of Completed) 17d. Signe And Consequence of Completed (Consequence of Completed) 18d. Decedent Signe Condens (Consequence of Completed) 19d. MAILINO 20a. METHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MICHOD OF DISPOSITION 19d. MAILINO 21. SIGNATURE OF FUNERAL SERVICE LICEUSEE 22. PART I. Enter the diseases, or complications that caused the death. Do not shock, or heart failure. List only one ceuse on each line. MMEDIATE CAUSE (Finel diseases or condition) 22. PART I. Enter the diseases, or complications that caused the death. Do not shock, or heart failure. List only one ceuse on each line. MMEDIATE CAUSE (Finel diseases or condition) 23. PACE (Finel MICHOD AND AND AND AND AND AND AND AND AND AN	4. SOCIAL SECURITY NUMBER 317-16-1965 9a. 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PACILITY NAME (if not institution, give street and number) PETTY POINT MEDICAL Center 10. COUNTY M. STATE 10. STATE 100. COUNTY 10. STREET AND NUMBER 3. DECEDENT 10. STATE 10. STATE 10. STATE 10. STA	4. ADE (IN 79 MATER) 3.17-16-1965 1. W 2 P OT WAS CONTROLLED ON SOUTH MATER OF DESTINATION OF Not Not Not Not Not Not Not Not Not Not	S. DECEDENTS EDUCTION S. DECEDENTS SUMMER (First, Modes, Last) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER SUMMER SUMMER (First, Modes, Modes Symmetry) S. DECEDENTS SUMMER SU

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the he filed uniting 20 hours after aleast with the Chair Bank and Marral Harings may be had a property of health and Marral Harings may be had been as a common of the chair and health and Marral Harings may be had been as the chair and health	be med within 12 rooms are been min one case bopt. Or regul any mental systems provide bound, constantly, or selected the medical examiner must be notified at once.

	(First, Middle, Last)								2. DA	TE OF DEATH	AY	YEAR	3. TIME OF DEATN
GEORGE LI					_						1995		8:10P
4. SOCIAL SECURITY N 181-18-5(066	5. SEX 1 📉 M 2 🗆 F	6. AGE (In y	rs. lest birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	24 HRS. MIN.		14/24		Countr	STOWN, PA.
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RESIDENCE OF		, in. 21	.072			FORT	HOW	IARD			BA	LTIM	ORE
100. STATE MARYLAND	BALT	IMORE			Y, TOWN C								10d. INSIDE CITY LIMITS?
100. STREET AND NUM 258 HE	NRIETTA	AVF -				101	2122					IZEN OF V	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4	2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES :	S. ARMED 2 NO	1 '	I yes, spe	ENDENT (OF HISPAN	m, Puert	BIN? (Specify Yes o Ricen, stc.)		14. RACE Black Speci	
15,	DECEDENT'S EDU	CATION completed)	WII	Se. DECEDENT'S	work done i			ng	1	6b. KIND OF BUS	SINESS/IN		ITE
Elementary/Seconds		College (1-4 or 5	+)	DIS/	se retired.) ABILI	TY				DISA	ABLEC)	
17. FATHER'S NAME (Fir							18. MOTI	NER'S NA	ME (First	t, Middle, Maiden	Surneme)		
CONR		VICKROY		I 401 14111 114				FLS				LMAN	
MARION I	. , ,	N.I.								mber, City or Tow			
20e. METNOD OF DISPO	OSITION nation 3 - Rem			ACE AND DATE	OF DISPOS	ITION (Na.	me of	d A	0/	TE 20c. LO	CATION -	City or To	
21. SIGNATURE OF FUN		ENSEE /	IMAR	TLAND			D ADDRE	SS OF FA		2/1995	CROV	MSVI	LLE,MD
▶ Hillar	1d X					STA	LITM	CC E	LIME	RAL HOM		۸	
1,1,1,1,1,04,1	y/L. Sta	ll∕iógs J				311	1 Mo	unta	in	Road Pa	sade	na M	arvland 21
	or naart tallure.		t caused th	na daath. Do (not antar	311	1 Mo	unta	in	Road Pa	sade	na M	Approximata interval Batwee
23. PART I. Enter the shock, of IMMEDIATE CAUSE disease or condition resulting in death)	(Finai	confilications that List/only one cau	t caused thuse on each	ilne.	dary	311 the mod	1 Mo da of dy	unta Ing, suci	in has ca	Road Pa	sade ratory ar	na M	Approximata interval Batwee
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Marine Call Holls. 18

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	_	1 - STATE REGISTRAR	STATE OF MARYLAND	DEPAR	TMENT OF	HEALTH AND F DEATH	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) RO	bert Edward Wri	ght			2. DATE OF DEATH MONTH 04,	199	3. TIME OF DEATH 5:00 A	м
_		4. SOCIAL SECURITY NUMBER 214-66-3285	5. SEX 8. AGE (In yrs. la 1 1 1 1 3	st birthday) YRS,	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTN (Month, Day Year) NOV 22,	8.	BIRTHPLACE (State or Foreign Country) Maryland	
2, 3 should	NO.	9a. FACILITY NAME (II not institution, give street and number) Anne Arundel Medical Center 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis 9c. COUNTY OF DEATH Anna Arunde								
Jes 1,	L DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOC	ATION			10d. INSIDE CITY	=
DAV physician. burial-transit permit. Pages 1,		Maryland Anne	Arundel			Annapo	lis		1 X YES 2 NO	
n. Insit pe	FUNERAL	43 Dean Street,	Apt. 1			2140)1		JSA	
TLAND ZIZIS-00Z0 by the hospital or attending physician be detached for use as the burial-trai at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AT FORCES? 1 YES 2 THE IF YES, GIVE WAR OR DATES	BMED NO	If yes,	ECENDENT OF NISPA specify Cuban, Mexico ES 2 NO Specifi	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)		t. RACE — American Indian, Black, Whita, atc. Specify: Black	
r attendi		15. DECEDENT'S EDUC (Specify only highest grade		ECEDENT'S	USUAL OCCUPA: vork done during i se retired.)	TION most of working	16b. KIND OF BU	ISINESS/INDUS		
Spital or hed for t	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	able		ITY GUARD	Digable	A STAT	TE GOVERNMENT	
the hospit e detached	S	17. FATHER'S NAME (First, Middle, Last)				1	AME (First, Middle, Maider	Sumame)		
retained by 5 should be notified at	BE	Phillip I. 190, INFORMANT'S NAME (Type/Print)		b. MAILING	ADDRESS (Stree	t and Number or Rural	Martha E. Route Number, City or Tox			
- 2 2 a	2	Atha Luvenia Hasl					polis, MD		100)	
e 6 may rector, pa		20a. METHOD OF DISPOSITION 1	ovel from State 20b. PLACE cemetery, cre Metro	and date of the control of the contr	of disposition (ther piece) atory.	Inc. 05	/05/95 Ba	CATION - CH	y or Town, State	
DALIMOR state death. Page 6 m by the funeral director, emoval. lical examiner must		21. SIGNATURE OF FUNERAL SERVICE LIC	Dawn F. McDo	onald	Crema	and address of FA tion Soci	iety of Mar Rd. Balt:	ryland.	, Inc.	
hours after ed in by the or removal		23. PART i. Enter the diseases, or c shock, or heart failure.	omplications that ceused the da lat only one cause on each line	eath. Do n	ot anter tha m	noda of dying, aud	ch as cerdiec or reap	iretory arres	t, Approximate interval Between	
ted withings hours completely filled in ial, cremation, or re-		iMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CONSE		Arrest				Onset and Dea	
executed and com to burial,	NO	Sequentially list conditions,	DUE TO OPR AS A CONSE			î.			4 wks	
ysician prior b	RTIFICATION	if sny, laeding to immediata csuse. Enter UNDERLYING CAUSE (Disesse or injury	DUE TO (OR AS A CONSE				scholoh	٤	2 4000	
end it	ш	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF	7):	0			3.0	
at the death by the attel and Mental y injury, c	CAL C	PART II. Other aignificent conditions	a contributing to death but not	reaulting i	n tha underlyl	ng cause givan in	Part i. 24s. WAS AMPERFO		24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO	S
he law requires that the dea has been signed by the att s Dept. of Health and Menta n 23 shows any injury,	MEDIC	- lymphoma					1 YES :		COMPLETION DF CAUSE OF DEATH?	X
law requas been of 23 she		DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF DEA	TH YE	S NO	UNCERTAI	N 🗆		1 TYES 2 THE	
SICIAN: The certificate had the State D	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 JOO	26. PLAC HOSPITAL: 1 Unpatient 2 ER/Outpatient 3		OTHER:					_
HYSICIA this certif with the	PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. II	IJURY AT	28d. DESCRIBE HOW	INJURY OCCUP	łED	
DING PHYS After this death with	ВҰ	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — At he		M 1	YES 2 NO	***************************************			
TOR: after	ETED	4 Nomicide 6 Could not be determined	building, atc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	moet, lactory, on	160	26t. LOCATION (Street City or Town, State		Rurel Route Number,	
HOBPITAL OR A FUNERAL DIREC MIN 72 HOURS	COMPLETED		CIAN: To the best of my knowledge, de R: On the beste of examination end/or							
	BE	296. SIGNATURE AND TITLE OF CERTIFIER	arani up			29c. LICENSE NUI			IGNED (Month, Day, Year)	
(5)	일	30. NAME AND ADDRESS OF PERSON WHO				D326	19	_ ria	y 04, 1995	_
		31. DATE FILED (Month, Day, Year)	38 REGISTRAR GOIGN TUPE	Ahh	cpolis	Mol.				_
	j	MAY 0 8 1995 Ju	us discussion frances							



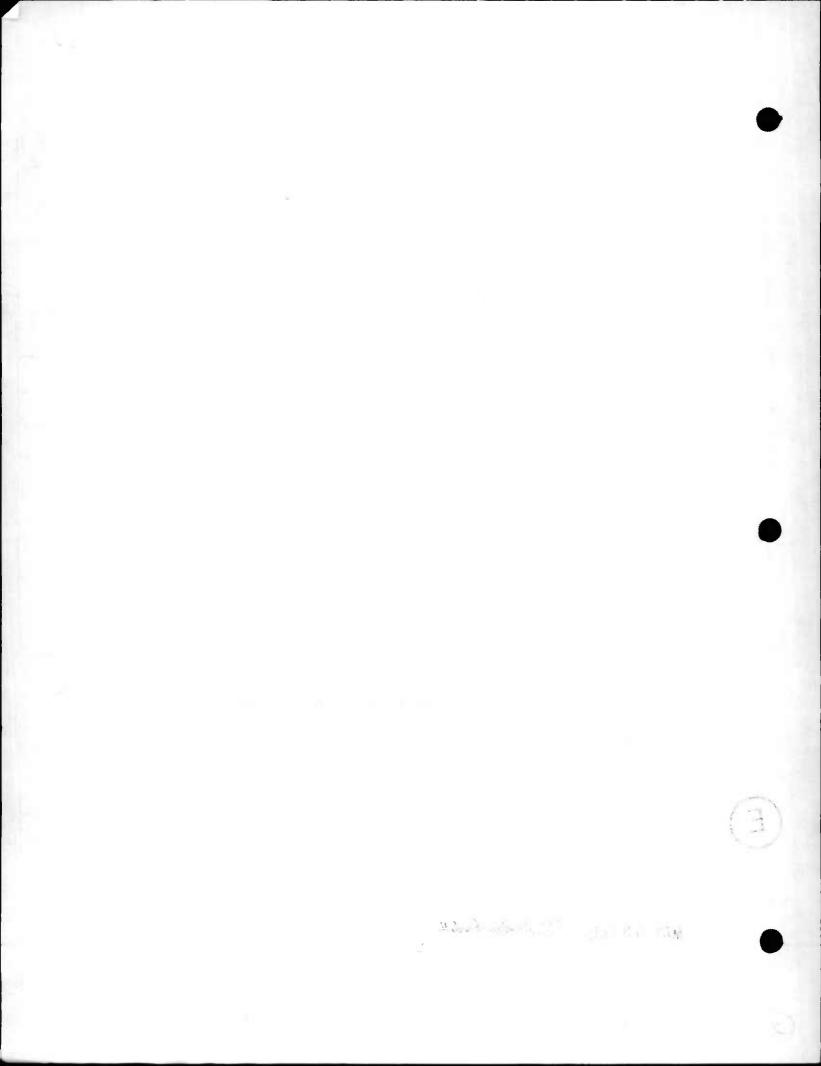
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SION OF VITAL RECORDS, P.O. BOX 68

	FOR STATE REGIST
•	1. DECEDENT
	4. SOCIAL SE 228-
I	9e. FACILITY
	Un
I	10e. STATE
	Mary1
	10e. STREET

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)						AY,	YEAR 3. TIME OF DEAT	
	Calvin 4. SOCIAL SECURITY NUMBER	Samuel Wya				May 3.		15 17.15	
	228-52-7251	1 X M 2 □ F 5	(in yrs. lest birthday)	MONTHS D	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) FEB 19, 1		e. BIRTHPLACE (State or Fo Country) Virginia	
	9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TO	WN OR LOCATION OF DE		9c. COUN	TY OF DEATH	
DIRECTOR	Union Memori	al Hospita	1		Balto. C:	ity	N/A	A	
R	10e. STATE 10b. COUNTY			TY, TOWN OR L				10d. INSIDE CITY	
	Maryland N/A				Baltimo	ore		1 📉 YES 2 🗌	
FUNERAL	10e. STREET AND NUMBER	4 . 50/			10f. ZIP CODE 2121		10g. CITIZEN OF WNAT COUNT		
NEI N	3100 St. Paul St.				USA				
BY FU	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	If ye	B DECENDENT OF NISPAN s, specify Cuben, Mexica YES 2 NO Specify	n, Puerto Ricen, etc.)	or No	14. RACE — American India Black, White, atc. Specify: White	
0	15. DECEDENT'S EDUC (Specify only highest grade	CATION	180. DECEDENT			16b. KIND OF BU	SINESS/INDU		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done durir ise retired.)	ng most of working				
MP M	11th		Counter	unter Salesman Plumbing & Hea					
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)		
BE	"Unknown"			Margaret Thomas NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
6	196. INFORMANT'S NAME (Type/Print)								
	Betty Lou Wyatt							e, MD 21218	
	t Burlat 2 Cremetion 3 Remo	Ne Me	PLACE AND DATE	natory,	Inc. 05/0	05/95 Ba	cation—c 1timo	re, MD	
	21. SIGNATURE OF FUNERAL SERVICE LIG			Cre	emation Soc	ciumy riety of Ma	arvlar	ad	
	George E. Mac	Nabb		299	Frederick	Rd. Balti	imore.	MD 21228	
CERTIFICATION		DUE TO (OR AS A	d Live	en a			ally	2-3	
EDICAL	PART II. Other significent conditions	contributing to death b	ut not resulting	in the under	lying cause given in	Pert I. 24a. WAS AN		24b. WERE AUTOPSY FI	
음	Coronary a	thry aft	uero oc	leron	3 -	t 🗆 YES 2		AVAILABLE PRIOR COMPLETION OF	
∑	DID TODA 660 UST 4	7						1 🗆 YES 2 🏂	
ÿ	DID TOBACCO USE C	ONIRIBUTE TO	CAUSE OF	DEATH	YES NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	8. PLACE OF DEATN (Ch	eck only one)			
ΥS	1 YES 2 NO 27. MANNER OF DEATN	1 M Inpetient 2 ER/Outp		4 - Nursing	Nome 5 Residence		_		
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		JURY M 1	: INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCI	URED	
8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	atreet, factory,	office	281. LOCATION (Street e City or Town, State)	and Number o	or Rural Route Number,	
COMPLET		CIAN: To the best of my know R: On the beste of examination							
BE	296. SIGNATURE AND TITLE OF CERTIFIER	H.D.			29c. LICENSE NUM AT 243 8	4BER 39 4 6		signed (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO EL-HABR, Abda	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type 201 E	o, Print)	pkw, Bo	altimore	, HIS	()	
	MAY 0 8 1995 Aug.	B2. REGISTRAND SIGN	AL PRE						



the hos	detache		once.
TO THE HIGH AND GRAND PHYSICIAN. The law requires that the death certificate be executed within the mount after death. Page 6 may be retained by the hos	TO THE PURCHAL DIRECTIFIC After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: Ill man 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Page 6	direct		er m
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	1 - FOR STATE REGISTRAR	STATE OF N	IARYLAND / CE	DEPARTMEN ERTIFICAT	T OF H	EALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	ELLIE	BEAT	RICE V	Vio	ENER	2. DATE OF DEATH ON THE APRIL 2	Jo, 199	S. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 214-18-6472	5. SEX 1 M 2 F	6. AGE (In yrs. las		ER I YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)		
OR	90. FACILITY NAME (If not institution, give s Greater Baltimor		0		-	OR LOCATION OF DE	9c. COUNTY				
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c. CITY, TOWN		TION			10d, INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	1 VES 2 NO									
CNE	15415 YORKR	12. WAS DECEDEN	T EVER IN U.S. AR	IMED 13	, WAS DEC	s or No — 14.	14. RACE — American Indian, Black, White, atc.				
BY FUNERAL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 X	40	If yes, sp		Specify:				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)										
BE COM	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Samuel Thomas 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Betty Cole										
10	198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15415 YORK Rd. SPARY, MARYLAND 2182										
	20a. METHOD OF DISPOSITION 1XC Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, crematory or other place) Removal from State 20c. LOCATION — City or Town, State Parkton ARY And										
	21. SIGNATURE OF FUNERAL SERVICE LIC	PLOU	0.	22	NAME A	D ADDRESS OF FA	EL OS CHI		M 1 3:00		
	23. PART I. Enter the diseases, pr (shock, pr heert fellure.	complications that List only one cau	caused the de	ath. Do not ante	r the mo		h aa cardlac Dr reep	iratory arrest			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Onset and Death Onset and Death Onset and Death										
Z											
CATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	c	(OR AS A CONSE								
CERTIFICATION	thet initieted events resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE OF):							
·	PART II. Other aignificent condition	e contributing to	deeth but not r	eauiting In the u	ınderlyin	g cause given in	Part I. 24a. WAS AP		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
PHYSICIAN: MEDICAL	COPP, CH						1 YES :	2 NO	COMPLETION OF CAUSE DF DEATH? 1 YES 2 SENO		
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					ACE OF DEATH (Ch	eck only one)				
YSIC	1 TES 2 NO	HOSPITAL:			irsing Hom		8 Other (Specify)				
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, De	INJURY Ry. Year)	28b. TIME OF INJURY M		URY AT PRK? YES 2 NO	28d. DESCRIBE HOW	Bd. DESCRIBE HOW INJURY OCCURED			
	3 Suicide 8 Could not be 4 Homicide datarmined	28s. PLACE O building,	F INJURY — At ho atc. (Specify)	ime, farm, atree1, ta	ctory, offic		281. LOCATION (Street City or Town, State		Rural Route Number,		
COMPLETED							to the cause(a) and ma		Buse(s) and manner as stated.		
BE C	296 SIGNATURE AND TITLE OF CERTIFIER	2	0	- 0		29c. LICENSE NUI			GNED (Month, Day, Year)		
0	VIVan h	/>/) "	Y)		032	743	1 4	158/22		

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

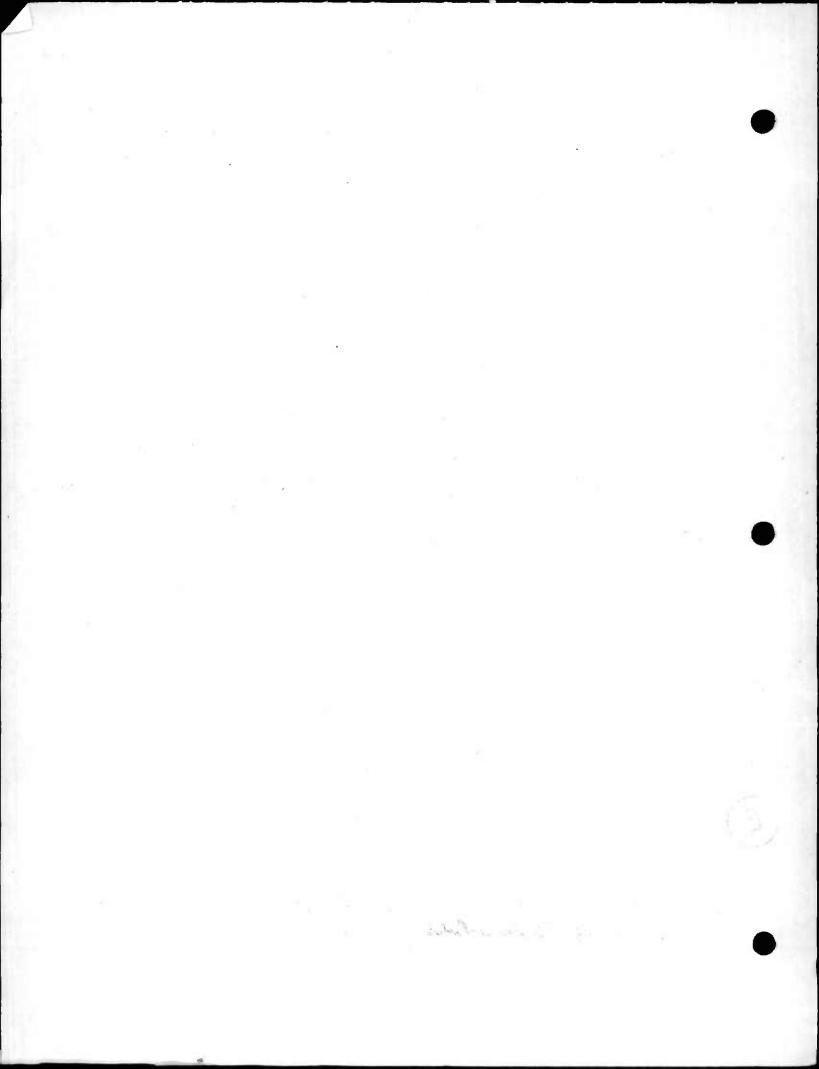
STROMBERG

34. REGISTRAR SOIGNATURE

THE SHARE SOIGNATURE

DR. MARK S 31. DATE FILED (MONTH, Day, Year) MAY 0 8 1995

Towson, Md. 21204



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11767

95-2527-005 blh ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/14/95 t.t Item # 1 Film # G 723 5-8-95 N.A. Per Funeral Home

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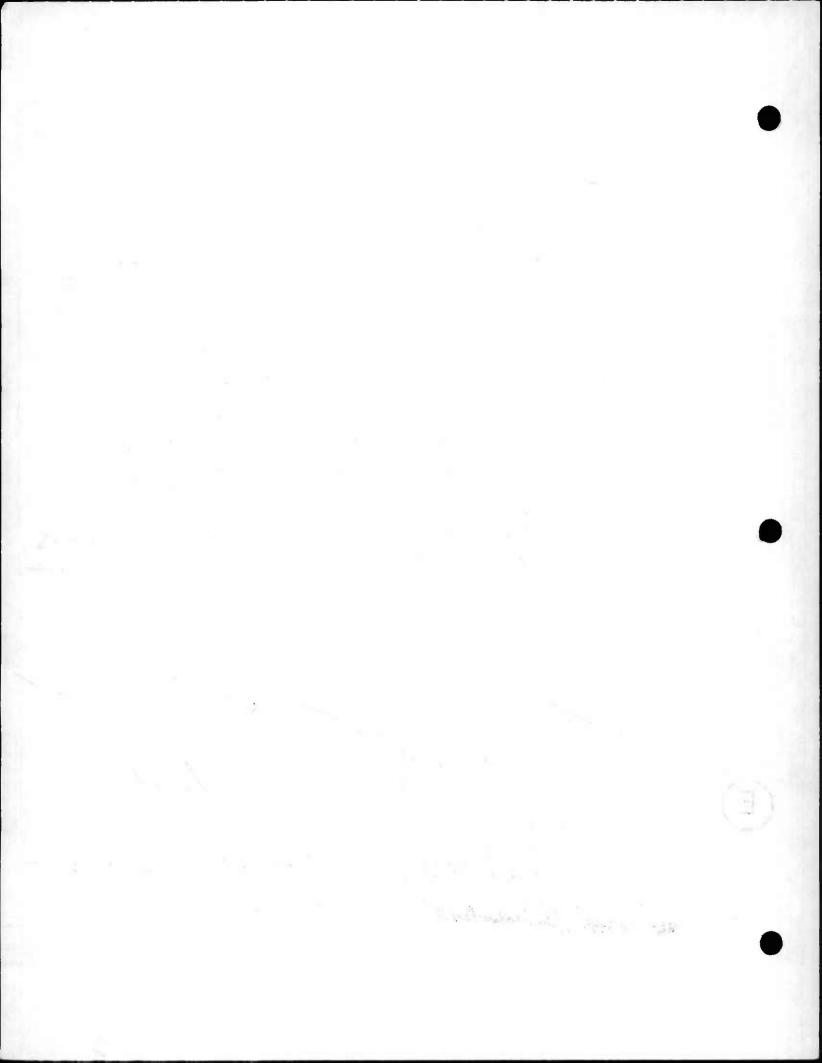
	FOR STATE REGISTRAR	STATE OF N	MARYLAND	/ DEPAR	TMEN	T OF H	EALTH DEA	AND I	MENTAI	HYGIEN			
	1. DECEOENT'S NAME (First, Middle, Last)				_	tfie			2. DATE	OF OEATH			3. TIME OF OEATH
	William	Le	e		W	itf	el d		Apr		0 19	YEAR 95	1948 M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	lest birthday)		I YEAR	IF UNDER	_	7. DATE	OF BIRTH			HPLACE (State or Foreign
	213-86-8705	1 🖾 M 2 🗆 F	2	27 YRS.	MONTHS	DAYS	HOURS	MIN.		. 3, 1	1967		YLAND
_	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CIT	r, TOWN	R LOCATI	ON OF DE			7	INTY OF D	
DIRECTOR	7617 Hackett		Dundalk							Baltimore			
분	10a. STATE 10b. COUNT	10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY	
	MARYLAND	BALTIMORE CITY								1)∑ YES 2 □ NO			
FUNERAL	10e. STREET AND NUMBER					101	. ZIP COD				WHAT COUNTRY?		
l iii	4828 PIMLICO ROAI		21215										
5	11. MARITAL STATUS 1 X Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT C	OF HISPAN	IC ORIGIN	? (Specify Ye	s or No—	14. RACI	E — American Indian, k, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR OATES	If yes, specify Cuban, Mexican, Puerl R OR OATES If yes, specify Cuban, Mexican, Puerl 1 ☐ YES 2 ☒ NO Specify:								Spec	
	15. DECEDENT'S EDU	1											ACK
COMPLETED	(Specify only highest grade	completed)	184.	DECEDENT'S (Give kind of IIIe. Do NOT u	Work done	CCUPATIO during mo	ON st of workin	ng	16b.	16b. KIND OF BUSINESS/INDUSTRY			
ا ترا	Elementary/Secondary (0-12)	College (1-4 or 5 +)										
N N	GED			CONS	TRUC	TION	WOR			ONSTRU		N CO	MPANY
	17. FATHER'S NAME (First, Middle, Last)								ME (First, A	fiddle, Meiden	Surname)		
H	ROYCE	WHITFIEL					LOT			AE	McQU		
2	19a. INFORMANT'S NAME (Type/Print)	-								er, City or Tow			
-	ROYCE WHITFIEL		4	1828 P	IMLI	CO R	OAD,	BAL	TIMO	RE, MA	ARYLA	ND 2	1215
	20a. METHOD OF DISPOSITION 1. Buriel 2 Cremation 3 Rem	ovel from State	20b. PLAC	E AND DATE	OF DISPOS	SITION (Na	me of		OATE	20c. LO	CATION —	City or To	own, State
	4 Donation 5 Other (Specify)		MT	ZION	CEME	TERY		5	-6-9	5 BAI	TIMO	RE.	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			22.	NAME AN	D AOORES	SS OF FAC	CILITY				
	• (h).	12			J	OSEP	H H.	BRO	WN J	R FUNI	ERAL	HOME	,P.A.
	IMMEDIATE CAUSE (Final disease or condition countries and interval Bet Onset and interval B										Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
	DARK II OU												
Ä	PART II. Other aignificant condition	s contributing to	daath but not	resulting	in tha ur	darlying	causa g	given in i	Part i.	24a. WAS AN PERFOR		24b.	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC									_ [1 YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
¥													1 YES 2 NO
ž	DID TOBACCO USE CONT	RIBUTE TO CAI	USE OF DE	ATH YE	S 🔲 I	NO [UNC	ERTAIN	1 🗆				
- 5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL	ACE OF DEAT									
Š	1 X YES 2 INO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER	रे: sing Home	5X Re	sidence (8 🗆 Other	(Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF (Month, Da	INJURY	FUU NED	-	28c. INJU		T		CRIBE HOW I	NJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	FOUND: 4	-30-95	4:30	PM	1 🗌 Y	ES 2	NO	UNKNO	WN			
	3 Suicide 8 (Could not be	28a. PLACE OF	INJURY - At I	home, farm, s	treet, fact	ory, office			28f. LOCA	TION (Street a	and Number	or Rural R	Toute Number
Ē	4 Homicide determined	building, i	etc. (Specify)	FOUND:	REST	DE NCE		- 1	City o	MORE, MI	7617	HACKE	TT AVE.
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	ny francoity is				-						
M	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of a	amination and	weath occum	at the t	me, data	and placs,	and due t	to the caus	e(s) and mar	mer as stat	led.	
8				- investigatio	, iti my c	pimon, de	ern occur	t ent na be	irne, data i	and place, an	d dua to th	e cause(s) and manner as stated.
BE	286. SIGNATURE AND TITLE OF CERTIFIER			-			29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
0	Meagre 1	Tend	, re	a			0.0	C.M.	E.		May	y 01	. 1995
- 1	30. NAME AND ADDRESS OF PERSON WH	· _ \											
	1/E APORE MIT	ing	1	11 P	enn	Str	eet	, Ba	lti	more,	Ma	ryla	and 21201
	31. DATE FILED (Month, Day Joar)	REGISTRA	S SIGNATURE										

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		1 - STATE REGISTRAR		STATE OF I	MARYL					DEAT		MENTA	L HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, I		NADE!								MON	_		/EAR	. TIME OF DEATH
	-	MARY LE 4. SOCIAL SECURITY NUMBE	T.	S. SEX	6. AGE	(In yrs. last bin	thday)	IF UNDER	1 YEAR	IF UNDER	24 1498	7 DATE	0.5 OF BIRTH	199		4:30 P M
_	DIRECTOR	219-05-1454		1 🗌 M 2 💢 F	74		YRS.	MONTHS	DAYS	HOURE	MIN,		rh. Day. Ybar) 1.4,19	20	Country)	YLAND
2, 3 should		90. FACILITY NAME (If not inst MERIDIAN MUI	TI-ME						OWS	PR LOCATI	ON OF DE		1,120	9c. COUNT	Y OF DEA	
←		RESIDENCE OF DECE	10b, COUNTY			10	De. CITY	Y, TOWN (OR LOCAT	ION						4 "10105 0171
ft. Pages		MARYLAND	BALT	IMORE		"			TIMO							Dd. INSIDE CITY LIMITS? YES 2 NO
i. insit permit.	FUNERAL	100. STREET AND NUMBER 3308 WASHING	GTON BI	LVD.,					101	. ZIP COD	2122	27				AT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 N 3 Widowed 4 Divorce	ferried	12. WAS DECEDEN FORCES? 1 IF YES, OIVE V	I YES	2 VNO			If yes, sp	ENDENT Cube	n, Mexica	n, Puerto	N? (Specify Yes	8 or No — 14	Black, V Specify:	- American Indien, White, etc. WHITE
12 E O E	PLETED	15. DECEI (Specify only in Elementary/Secondary (0-1 12TH	DENT'S EDUCA highest grade of	College (1-4 or 5	+}	life. Do	NOT us	USUAL Or work done e retired.)	during mo	ON st of working	ng	16	b. KIND OF BU	SINESS/INDUS		G
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	BE COMPL	17. FATHER'S NAME (First, Mid- LEO KRIMMELE	BEIN							MAR	Y KE	SSLI		Surname)		
. 2 8 0	10	RONALD WADE				331	AILING W	ADDRESS ASHI	S (Street e NGTC	N BL	or Rural F	BA]	TIMOR	E, MD		227
MOF mector,		20a. METHOD OF DISPOSITIO 1 Suriel 2 Cremetion 4 Donation 6 Other (S	3 🗆 Remov Specify)		20b	D. PLACE AND	THE	DERA	L CE	METE		5/8	BA1	CATION — CIT LTIMOR		, State
BALTIN ter death. Pag the funeral di yal.		21. SIGNATURE OF FUHERAL	esa	4	K	lug		41	07 W	ILKE	NS A	VEN	OME, IN JE-BALT	CIMORE		21229
S bd within 24 hours after ompletely filled in by the Li cremation, or removal event, the medical	disease pr condition										t,	Approximata Interval Between Onset and Death				
OX 68/60 e be executed wit sician and comple whor to burial, cre- traumatic even	NO	Sequentially list condition	DUE TO (OR AS A CONSEQUENCE OF):													
ficate be physician ne prior the pri	FICAT	if any, isading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury	DUE TO (OR AS A CONSEQUENCE OF):													
U.S., F.O. BO the death certificate the attending physical Mental Hygiene pri	CERTIFICATION	that initiated events reaulting in death) LAST														
that the and and	MEDICAL	Anemia	conditiona	contributing to	death b	out not read	Iting i	n the un	deriying	Ceuse (lven in	Part i.	24a. WAS AN PERFOR	MED?	CC	ERE AUTOPSY FINDINGS WILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
E Dee E		DID TOBACCO US	F CONTRI	BUTE TO CA	USE O	DE DEATH	YF	ς Π I	VO [LINC	ERTAIN		,		1	VES 2 NO
	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			28. PLACE OF	_	H (Check	only one)	0140	LKIAII	4 1				
SICIAN: The Certificate the State	YSK	1 TES 2/ NO		HOSPITAL:		patient 3 🗆 D	AOC	4 Nun		5 🗆 Re	sidence	8 🗆 Oth	or (Specify)			
G PHY C	ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident	ending vestigation	28s. DATE OF (Month, D	Pay, Year)		b. TIME	M		RK?] NO	28d. DE	SCRIBE HOW I	NJURY OCCUP	RED	
NO WAR			ould not be termined	28e. PLACE O building,	etc. (Spec	f — At home, i	ferm, a	treet, fact	ory, office	1		28f. LOC City	ATION (Street a or Town, State)	and Number or	Rural Rout	e Number,
O SOUTH	COMPLET	one) 2 MEDICA	AL EXAMINER:	AN: To the best of On the bests of e												nd manner ae atated.
TO THE TO THE Be filed	O BE	296. SHOWATURE AND TITLE O	ABCU.	Caffer	ra	nn		>			33 2			29d. DATE S		onth, Day, Year)
10	É	30 NAME AND ADDRESS OF F	BELL	COMPLETED CAUSE	SE OF DE	ATH (ITEM 27)	(Type,	Print)	Sù	te S	78	144	7 You	LROA	سارا	theville Me
		31 MAY PILED (M811/1995	3" Jali	d'abidane	4500	ADAE						·				3



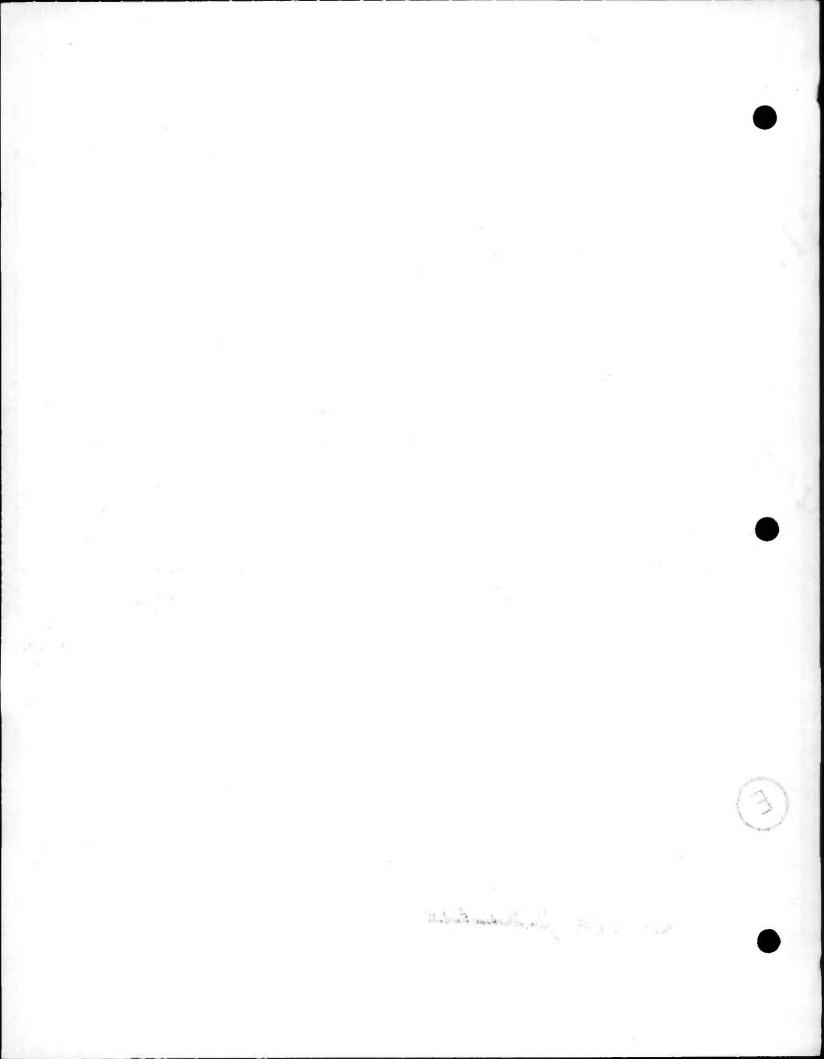
4. SOCIAL SECURITY NUMBER 214-12-9416 1 M 2X F 73 YRS. 6. AGE (in yrs. last birthday) YRS. 8. AGE (in yrs. last birthday) YRS. 8. AGE (in yrs. last birthday) YRS. 8. AGE (in yrs. last birthday) YRS. 8. AGE (in yrs. last birthday) WONTHS DAYS HOURS MIN. 99. FACILITY NAME (if not institution, give street end number) Manor Care-Towson RESIDENCE OF DECEDENT	EATH DAY YEAR 3. TIME OF DEATH 4 1995 3:05 A N								
4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2X F 73 YRS. S. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (Month, Day, MATCh) F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BUILDING (MONTH) T. DATE OF BUILDING (MON									
9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH	RTH 8. BIRTHPLACE (State or Foreign Country)								
Manor Care-Towson Towson RESIDENCE OF DECEDENT TOWSON	9c. COUNTY OF DEATH								
HESIDENCE OF DECEDENT	Baltimore								
10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary and Anne Arundel Crofton									
	1 Tyes 2 X NO								
100. STREET AND NUMBER 1906 Layton St. 21114	10g. CITIZEN OF WHAT COUNTRY?								
1906 Layton St. 21114 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican.	U.S.A.								
3 🖾 Wildowed 4 🗆 Divorced IF YES, GIVE WAR OR DATES 1 🗀 YES 2 🔯 NO Specify:	ecity Yes or No- etc.) 14. RACE — American Indian, Black, Whits, etc. Specity: White								
(Give kind of work done during most of working	OF BUSINESS/INDUSTRY								
Elementary/Secondary (0-12) College (1-4 or 5+) 10 yrs College (1-4 or 5+) Bookkeeper Tran	gnomba bi a u								
10 yrs Bookkeeper Tran 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Last)	sportation								
Edward J. Ritz Margaret N. K									
19b. MAILING AOORESS (Street and Number or Rural Route Number, Cit									
1906 Layton St. Crofton Md.									
1 💆 Burisi 2 🗆 Cremation 3 🗆 Removal from State Commetory, crematory or other places,	20c. LOCATION — City or Town, State Baltimore, Md.								
21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
Ruck Towson Funeral 1050 York Rd. Towson	Home, Inc.								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Out TO FOR AS A CONSEQUENCE OF Sequentially list conditions,	Intervel Between								
If any, leading to immediate cause. Enter UNDERLYING									
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST BY THE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									
That initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s.	WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
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THE TOTAL STANDARD TO SET TO CAUSE OF DEATH YES NO NOTESTAIN TO SET MAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DOO 1 Ingress of PROMOTION 1 Ingression 3 DOA 1 PTHER.	PERFORMED? YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2								
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THE THAT II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algnificent conditions contributing to death out of part II. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I.	PERFORMED? YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? I WES 2 NO MUNICIPAL PROVIDED NUMBER, State Number of Fund Route Number, sand manner as stated.								



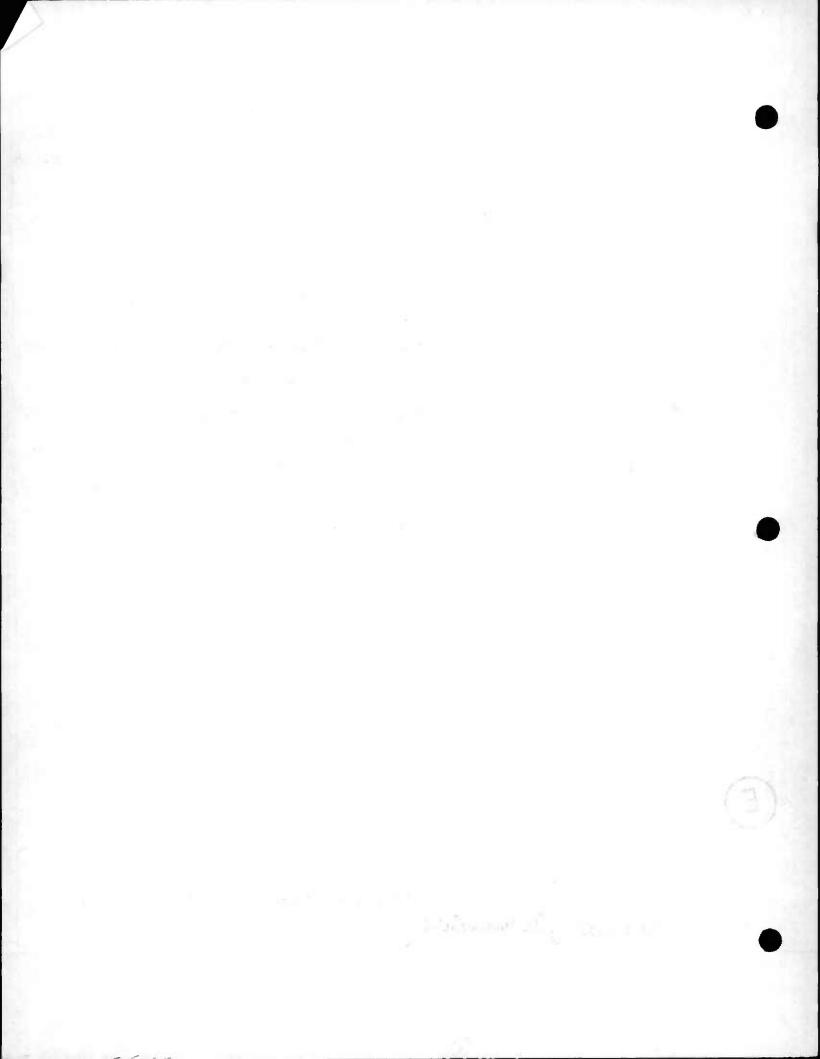
DWISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HUSPING OF TITLE HECORDS, P.O. BOX 68760 TO THE HUSPING OF TITLE STATE CHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the host TO THE RIMERA CHECKEN AND STATE STATE BORD. Of Health and Mental Hygiene prior to bunal, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA			HEALTH AND F DEATH	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)	Weav				MON	E OF DEATH		YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 6. AGE (In yrs. last birthday) 1 WONTHS DAYS HOURS MIN. A TO ATE OF BIRTH (Month, Day, Vear) YRS. 7. DATE OF BIRTH (Month, Day, Vear) 4. SOCIAL SECURITY NUMBER 24 HRS. 7. DATE OF BIRTH (Month, Day, Vear) 7. DATE OF BIRTH (Month, Day, Vear) 7. DATE OF BIRTH (Month, Day, Vear)									ACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give street Howard County General RESIDENCE OF DECEDENT		al		N OR LOCATION OF I	DEATH			ry of DEA	ounty
DIRECTOR	10a. STATE 10b. COUNTY	ce Georges		y, town on Lo		··				Dd. INSIDE CITY LIMITS? YES 2 [3] NO
3AL	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZE		AT COUNTRY?
NE	2307 Oxon Run Drive		II.O. ADMED	10.000	JSA					
BY FUNERAL	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR OA	2 NO	it yes,	apecify Cuban, Maxie E\$ 2 XXIO Spec	IN? (Specify Yea Rican, etc.)	(Specify Yea or No- can, etc.) 14. RACE — American Indian, Black, Whita, atc. Specify: Black			
COMPLETED		TION Impleted) College (1-4 or 5 +)		work done during se retired.)	TION most of working	16	b. KIND OF BUS	OF BUSINESS/INDUSTRY N/A		
MP	C N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme)									
		rice Weaver						.,		
TO BE	Siron Maurice Weaver Traci Tayana Thompson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2307 Oxon Run Drive, Temple Hills, MD 20748									
	20e. METHOD OF DISPOSITION 1 M Surfal 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Camelegy, Cremation of Removal from State Camelegy, Cremation of Removal from State Columbia Memorial Park 5-8-95 Columbia, MD									
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME	AND ADDRESS OF F	ACILITY			a, rn	
	Gelenoleller	Mal	M0053		k Funera cott Cit				043	
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Extreme									
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEAT			IN L			<u> </u>	
YSIC	1 YES 2 NO 1	OSPITAL: Simpatiant 2 ER/Outpar	tient 3 🗆 DOA	OTHER:	me 5 🗆 Rasidence	6 🗆 Oth	er (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIM INJ	URY	NJURY AT ORK?	26d, DE	SCRIBE HOW II	JURY OCCU	RED	
red BY	2 Accident Investigation 3 Suicide 8 Could not be datarmined 4 Homicide 1 Hom								Rural Route	o Number,
COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: (IN: To the best of my knowle								od manner as misted
8	29b. SIGNATURE AND TITLE OF CERTIFIER	itson	ms		29c. LICENSE NU					onth, Day, Year)
TO	30. NAME AND ADDRESS OF PERSON WHO C	TSON, 116	TH (ITEM 27) (Type,	Print) TTLE /				4 (2012	imeink
	MAY 0 8 1995	32 PEGE TO PEG ON	U.S.							

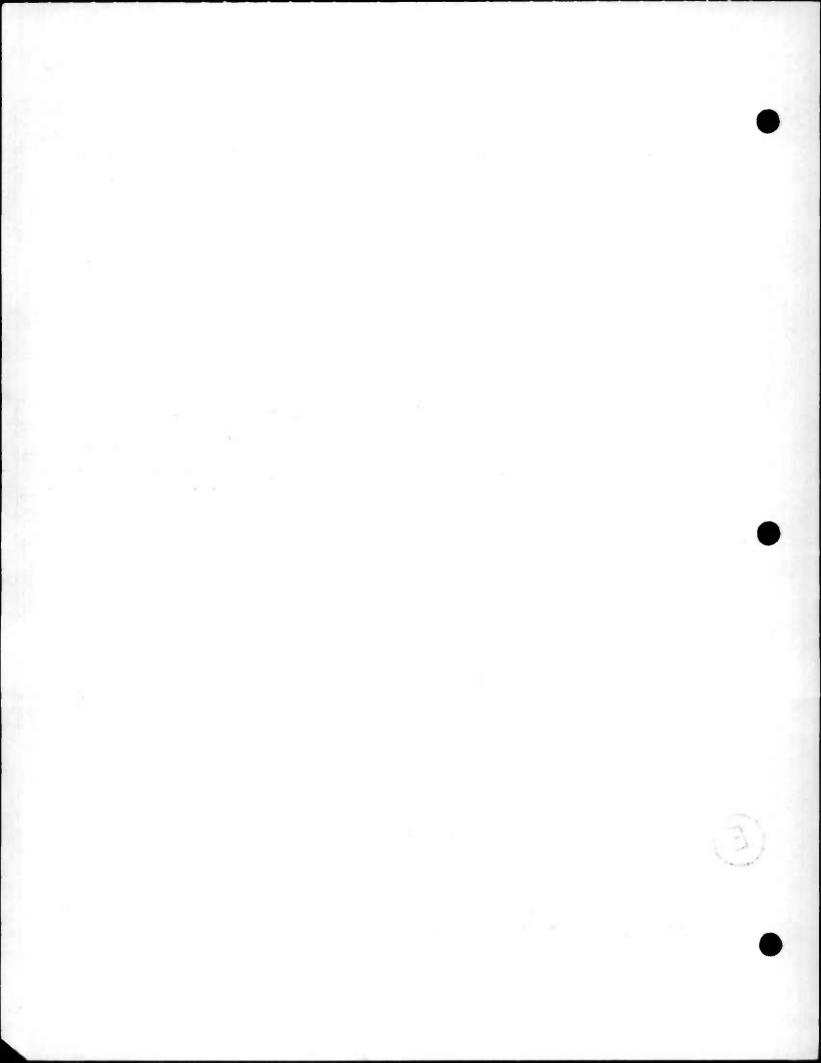


		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
		1. DECEDENT'S NAME (First, Middle, Last) Lee J. White								2. DATE O		, is	YEAR 3	. TIME OF DEATH 8:00 AM
	D BE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 061-22-1101	5. SEX 1 🔀 M 2 🗌 F	6. AGE (In yrs. las.	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE O		9	Country)	ACE (State or Foreign
, 3 should		sa. FACILITY NAME (If not institution, give a 916 N. Augusta A				9b. CITY		on Location			, JU 2	9c. COUNT	Y OF DEA	тн
s 1, 2,		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT				1.								
permit. Pages		Maryland 104. STREET AND NUMBER	N/A		10c. CITY, TOWN OR LOCATION Baltimore					9			- 1	Od. INSIDE CITY LIMITS? XYES 2 NO
. ist		916 N. Augusta A	venue		10f. ZIP CODE 2 1 2 2					10g. CITIZEN OF WHAT US				
BALTIMORE, MARYLAND 21215-0020 are death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit wal.		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	X YES 2 N		1 '	f yes, sp	ENDENT O	OF HISPANI In, Maxican Specify:	, Puarto Ri	(Specify Yea can, etc.)	or No — 1	4. RACE - Black, V Specify:	- American Indian, Whita, etc.
2121 tal or atter for use a		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Gi	ve kind of	work done one retired.)	CCUPATIO	ON list of workin	ng	16b, f	(IND OF BUS	INESS/INDU	STRY	
rLAND by the hospit be detached at once.		17. FATHER'S NAME (First, Middle, Last)	YRS	DIS	TRIE	UTIOI	√ (LEF	RK	FE	DERA	L Go	OVER	NMENT
YLAND 2 by the hospital be detached to at once.		UNKNOWN									ddle, Malden :	Sumame)	20,	44
MAR retained 5 should notified		19a. INFORMANT'S NAME (Type/Print)		196	MAILING	ADDRESS	(Street a		ACIL or Rural Ro		City or Town	, State, Zip C	OK (79
E, M	5	ROSELLA	WHITE		16.	N. A	UG	UST	A A	VEN	UE B	ALTO.	MD	, 2/229
BALTIMORE, after death. Page 6 may be by the funeral director, page noval. cal examiner must be 1		20a, METHOD OF DISPOSITION 1 Devial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from Stata	20b. PLACE A cematery, crer	natory or o	ther place!								
ALTIM death. Page t funeral dire f. examiner		21. SIGNATURE OF PUMERAL SERVICE LIC	ENSEE	BARK	500	22.	NAME AI	ND ADDRES	SS OF FACE	IUTY	95 ()	DINOS	11/2	LS, MD.
BAL the fune the fune oval.		*Ch	1/2	\sim		19	13	W. P	M. O	MAR	F ST.	BAIT	n M.	0, 2/223
in 24 hours ely filled in thation, or rer the media	MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or cannot shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one caus	caused the dese on each line. Cancer OR AS A CONSEC	of t	he S			ng, such	aa cardia	or respir	atory arres	st,	Approximate Interval Between Onaet and Death 5 months
BOX 68760 ate be executed with hysician and complete i prior to burial, cren r traumatic event		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	s	OR AS A CONSEO			-							
th certificate ending physical Hygiene p		that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
HDS, He hat the death but the death and Mental my injury, or		PART II. Other significant condition	contributing to	death but not re	sulting	In the un	derlying	cause g	iven in P	Part I. 2	4a. WAS AN A			ERE AUTOPSY FINDINGS
quires to quires to quires to quires to health tows as			PERFORMED? 1 □ YES 2 ⋈ NO							Landers .	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
law bas b Dept. 23		DID TOBACCO USE CONTI	RIBUTE TO CAL					UNC	ERTAIN					
E st = 1	SICI	EXAMINER?	HOSPITAL;			OTHER	1:	e E (Ve-	aldones @	Other (0			
N OF VI B PHYSICIAN: In this certification with the St narked, or it	BY PHYSICIAN:	27. MANNER OF DEATH 1 Xetural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, Da	NJURY	28b. TIM	_	28c. INJ WO				Specify)	JURY OCCU	RED	
	8	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY — At home, farm, street, tactory, of building, etc. (Specify)				ery, office	filce 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					e Number,	
	COMPLET	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and dus to the cause(s) and manner as stated.												
HOSPI FUNER Within		2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
TO THE HOSP TO THE FUNER be filed within	BE	Drottus Superium					29c. LICENSE NUMBER D24/49 29d. DATE SIGNED (Month, Date Signed)							
FFE	٩	Dorothy Snow, M.D., Staff Physician, 10 N. Greene St., Baltimore, MD 21201												
+1		MAY U 8 1995	32 REGISTRAF											



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Plant A MENDING PHYSICIAN: The law requires that the death certificate be executed withing a fler death. Page 6 may be retained by the hos	The control of the control of the state of the attending physician and completely filled in by the funeral director, page 5 should be detach		T. first 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
fter o	the	I was a mer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	aie	
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_	FOR STATE REGISTRAR	STATE OF MARY	AND / DEPA	RTMENT OF	HEALTH AND			0 10000		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEA	ATH DAY	YEAR 3. TIME OF DEATH				
	MARY A.			MAY 5		9:42 p M				
	218-78-4470	5. SEX 8. AGE	MONTHS DAYS	HOURS MIN,	7. DATE OF BIR (Month, Day,) O1 O	7 64	s. BIRTHPLACE (State or Foreign Country) JAPAN			
TOR	9a. FACILITY NAME (If not institution, give street THE JOHNS HOPKINS RESIDENCE OF DECEDENT		TY, TOWN OR LOCATION OF DEATH TIMORE CITY N/A							
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND HOWA	TY, TOWN OR LOCA	Indian College							
ERAL	100. STREET AHD NUMBER 6101 DOWNS AVE	10	21227		177	10g. CITIZEH OF WHAT COUNTRY? U.S.A.				
BY FUN	11. MARITAL STATUS 1. Never Married 2 Married 3 Wildowed 4 Divorced	N U.S. ARMED 2 NO ATES	If yes, s	CEHDEHT OF HISPAI pecify Cuban, Maxica S 2 X HO Specif	n, Puarto Rican, e	ffy Yes or Ho—	14. RACE — American Indian, Black, Whita, etc. Specity: WHITE			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	S USUAL OCCUPATION WORK done during mase retired.)	OH ost of working		18b. KIND OF BUSINESS/INDUSTRY U.S.GOVERNMENT					
ш	17. FATHER'S HAME (First, Middle, Last) DONALD C. YODER					18. MOTHER'S NAME (First, Middle, Maiden Surname) KIMIE HARA				
TO B	19a. IHFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DONALD C. YODER 8724 DOWNIE ROAD-SEVERN, MD. 21144									
	206. METHOD OF DISPOSITION LA Burlet 2 Commetted 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of State MEADOWRIDGE CEMETERY 5/10 ELKRIDGE MD.)									
	22. HAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD.									
	23. PART I. Enter the diseases, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart fellule. List only one ceuse on each line. Approximate interval Between Oneet and Death disease or condition									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST SEPSIS DUE TO (OR AS A CONSEQUENCE OF): SYSTEMIC LUPUS FRYTHEMATOSUS FLARE Two Weeks DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL	DATE II ON THE DATE OF THE PROPERTY OF THE PRO						RFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
N. M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐ N/A									
O C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? EXAMINER? COTHER:									
-¥S	1 VES 2 NO 1 Norther 2 ER/Outpetlant 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 288. DATE OF INJURY 289. TIME OF 286. IHJURY AT 284 DESCRIBE HOW IN THEY OCCURED									
ВУ Р	1 Hatural 5 Pending 2 Accident Investigation	(Month, Day, Year) IHJURY WOF M 1 V			WORK? YES 2 HO		10W INJURY OCC			
ETED	3 Suicide 8 Could not be detarmined 28a. PLACE OF IHJURY — At homa, farm, streef, factory, office building, etc. (Specify) 28b. LOCATIOH (Street and Number or Rural Route Number, City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAH: To the bast of my knowledge, death occurred at the fime, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the fime, data and place, and due to the cause(a) and manner as stated.									
	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICEHSE HUM	BER	29d. DATE SIGNED (Month, Day, Year)				
TO BE	Mueta Tor		M611	8		> 5/6/95				
	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21287 MONICA RAVINDRA SHAH MD 600 N. WOLFE ST-BALTIMORE, MD.									
i	MAY 0 8 1995	2. REGISTRAR'S SIGH								



YEAR

9c. COUNTY OF DEATH

BAZINSKY

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

BALTIMORE, MD

Approximate

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES NO

29d. DATE SIGNED (Mo

intervai Between

Oneet and Deeth

14. RACE — American Indian, Black, White, atc.

Specify: WHITE

3. TIME OF DEATH

4:57

10d. INSIDE CITY

1 YES 2 X NO

8. BIRTHPLACE (State or Foreign

MARYLAND

P

REG. NO.

May 6, 1995

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DISTOR OF ALL AL DECORDS, P.O. DOX 00/00	ATTENDING PHYSICIAN: 1
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1	HOSPITAL OR

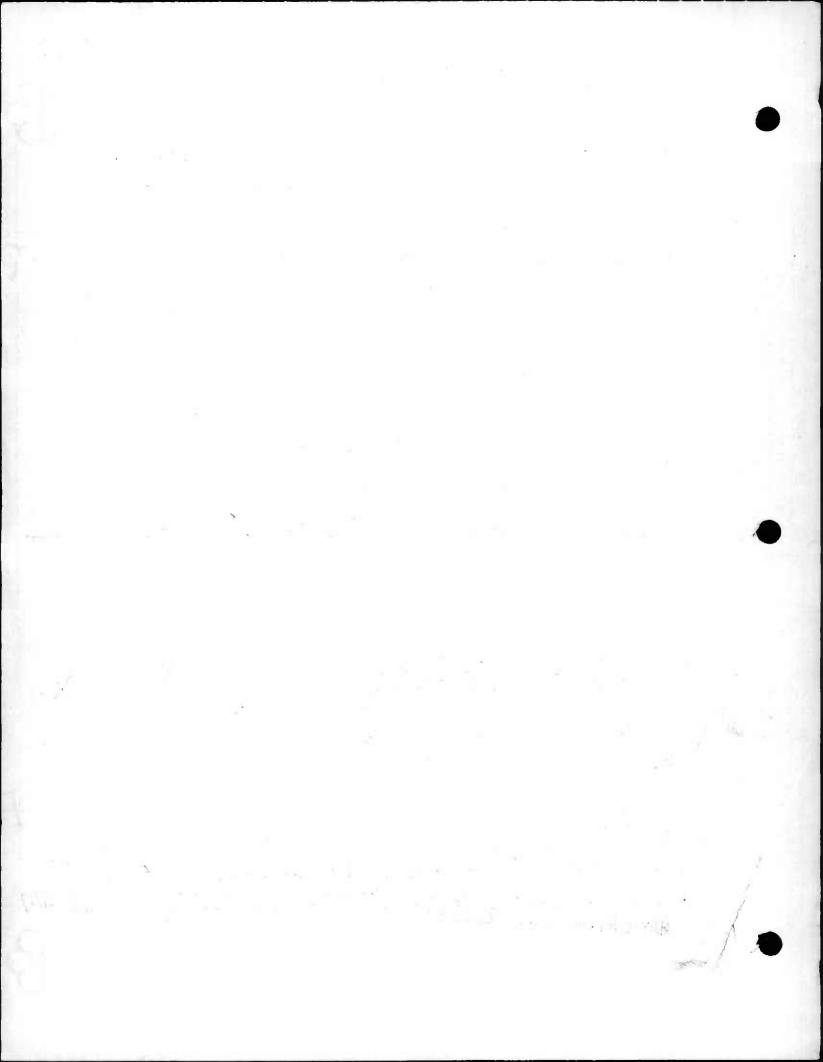
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 X M 2 | F DAYS HOURS 220-44-6382 88 SEPT. 14 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Manor Care Ruxton Towson 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE BALTIMORE permit. FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 7203 ROCKLAND HILLS DRIVE, APT. #403 21209 death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 1 Never Married 2 Married 1 TES 2 NO B 3 X Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5+ PHYSICIAN MEDICAL Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 MAX **ASHMAN** BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DR. MICHAEL N. ASHMAN 7206 DENBERG ROAD, BALTO., MD. 21209 pe 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must FEBREW 4 Donation 5 Other (Specify) MOSES MONTEFIORE-WOODMOOR examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. in by the f 6010 Reisterstown Rd, Baltimore, MD fter medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, ock, or heart fallure. List only one course on each line. 6 filled IMMEDIATE CAUSE (Finel the cremation, disease or condition resulting in death) nemic npiertely or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) and com burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury attending phy ntal Hygiene g DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in death) LAST the atten Mental P shows any injury. PART II. Other significant conditions contributing to ceath that not resulting in the underlying cause given in Part I. MEDICAL \$ 6 PERFORMED3 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL: OT/IER:

Nursing Home 5 - Rasidenca 6 - Other (Specify) 1 | Inpatient 2 | ER/Oulpatient 3 | DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this . marked, Natural 5 Pending BY 1 YES 2 NO After 2 Accident Investigation DIRECTOR: Aff hours after des item 28 is n 28s. PLACE OF INJURY — At home, larm, street, lactory, office building, stc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If its SIGNATURE AND THE BE 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTA CERTIFIC			MENTA	L HYGIENE			
			VE S.	AYRES			2. DATE MONT MA		199	CAD.	TIME OF DEATH 3:05 PM
pin		4. SOCIAL SECURITY NUMBER 213-20-2927	1 □ M 2 ☒ F	71 YRS. MO	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	May May	of BIRTH th, Day, Year) 23, 19	23 1	Mary]	
1, 2, 3 should	CTOR	99. FACILITY NAME (If not institution, give si Good Samaritan Ho RESIDENCE OF DECEDENT		91	Baltir	more	EATH		N/A	OF DEAT	н
Pages	DIRE	Maryland N/	Y /A		timore						d. INSIDE CITY LIMITS?
an. ransit permit.	FUNERAL	106. STREET AND NUMBER 4509 Roland Aver				1. ZIP CODE 21210			U	N OF WHAT	T COUNTRY?
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	DEENDENT OF HISPAI Decify Cuben, Mexica 3 2 NO Specif	an, Puerto	d? (Specify Yes of Rican, atc.)	or No 14.	RACE — Black, Wi Specify:	American Indian, hite, etc.
27 alor for u	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEOENT'S USI (Give kind of work life. Do NOT use re	k done during mo etired.)	ost of working	16t	. KIND OF BUSH		TRY	
8 A A	E COMPL	17. FATHER'S NAME (First, Middle, Last) John Julius Sch	5-22	Legal Se	cretary	18. MOTHER'S NA		Judic Middle, Maiden S Truetl	iumame)		
MAH retained 5 should notified	TO B	190. INFORMANT'S NAME (Type/Print) George Parkhurst				ert St.,	Route Num	ber, City or Town,	State, Zip Co		
		20e. METHOD OF DISPOSITION 1	oval from State	petery, cremetory or other Green Moun	it Crema	ame of atory ND Accress of FA	5/9		timor		aryland
BAL I IMOR s after death. Page 6 m removal. idjeal examiner must	Ц		awson		Mitch 6500	hell-Wied York Roa	defel	Baltimo	re. M	aryl	and 21212
tely fill, nation,		23. PART I. Enter the diseases, or call and the services of the services of the services of the services or condition resulting in death)	Liet only one ceuse on e	each line. LA CRANIA	enter the mo	ode of dying, suc	ch aa card	diec or respire	itory arrest	9	Approximate interval Batween Onset and Death
executed and com burial,	CATION	Sequentially list conditions, if any, leading to immediate	a HYPE	A CONSEQUENCE OF): RTENSIU A CONSEQUENCE OF):	N						50 YEARS
certificat ding phy Hygiene p	ERTIFICAT	ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):	CONSEQUENCE OF):						
that the of by the thand Me	AL C	PART II. Other algorificent condition	e contributing to deeth b	out not resulting in the	he underlying	g ceuse given in	Pert I.	24a. WAS AN A PERFORM	IED?	AVA	RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE
e law requires the has been signed Dept. of Health (AN: MEDIC	DID TOBACCO USE CONTR				UNCERTAIL	N 🗆	1		100	DEATH? YES 2. NO
F 9 9 E	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HO9PITAL: 1 ☑ Inpetient 2 ☐ ER/Outp	patient 3 DOA 4	THER:	ne 5 🗆 Residence	8 🗆 Othe	r (Specify)			
Re this PH C	ВУ РНУ	27. MANNEB OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 7	YES 2 NO		SCRIBE HOW IN.			
S S S S S S S S S S S S S S S S S S S	LETED	3 Suicide 8 Could not be determined	building, atc. (Spec	слу)			City	ATION (Street en or Town, State)		Rural Route	Number,
TO THE HOSPITAL IT TO THE FUNERAL IT DE FIER WITHIN 72 P. IMPORTANT: IF IN	COMPLETE		CIAN: To the best of my knowl R: On the beste of examination			leath occured at the	time, date	end place, end	due to the ca		
TO THE De filed IMPOR	TO BE	30. NAME AND ADDRESS OF PERSON WHO	- MD.	ATM (ITEM 27) /Ama Orio	(me)	0457			> M	AY E	nth, Day, Year) 6, 1495
10		DENNIS ROY	IMPER10	G000 S.	AMAR	ITAN H	USPI	TAL 5	1601 L BA	oct 1	RAUGN BUR 40 ZIZ39
		MAY 0 9 1995 Jul	RECISTRAR SIGN								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

1 YES 2 NO

Maryland

10g. CITIZEN OF WNAT COUNTRY?

9c. COUNTY OF DEATH

USA

11:35 PM

FOR STATE REGISTRAR 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH APRIL 15 KIMBERLY ANTHONY Ann 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day (bar) 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 216-92-6594 DAYS HOURS 1 M 2 FF 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR 2105 BOONE STREET BALTIMORE CITY Pages 1. 2. RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION NA Baltimore Maruland permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 21218 2527 Barclay Street after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 KNO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION ntary/Secondary (0-12) College (1-4 or 5+) NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Eleanor Addison 띪 Garrison Anthony 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Ploute Number, City or Town, State, Zip Code) 2 Diane Brown 9 20a, METHOD OF DISPOSITION
1 Burlal 2 Cremular
1 Donallon Other (5) 20b. PLACE AND DATE OF DISPOSITION (Name of westren Star Cemetrey

One of the color of t must examiner illed in by the fu medicai 23. PART I. Enter the disasses, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition NARCOTIC AND ALCOHOL INTOXICATION resulting in death) and complete DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. BOX 6876 traumatic CERTIFICATION Sequentially list conditions, 9 OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL been signed by the any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate h **EXAMINER?** L OR ATTENDING PHYSICIAN: TI DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTHER: 1X XYES 2 □ NO 1 Dinpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 🗆 Residence &XIXther (Specify) AT SCENE 0 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH FOUND M with t 28c. INJURY AT WORK? marked, 1 Natural Pending 1 YES 2 XX NO ВУ 4-15-95 FOUND 2 Accident 28e. PLACE OF INJURY — At home, Ierm, strest, factory, office building, etc. (Specify) 3 Suicide 60 8)(X) Could not be COMPLETED 4 Homicide FOUND IN HOUSE BALTIMORE. tem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL I within 72 h HOSPITAL 2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. PORTANT: SIGNATURE AND TITLE OF CERTIFIER

PLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

M.

15

14. RACE — American Indian, Black, While, atc. Alsocity: Afro american 16b. KIND OF BUSINESS/INDUSTRY Baltimore, Maryland 21218 20c. LOCATION — City or Town, State Catonville, Maryland No ADDRESS OF FACILITY 1639 N. Broadway 21213 Baltimore, Maryland Approximate Interval Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO 28d. OESCRIBE HOW INJURY OCCURED SUBJECT INGESTED DRUGS AND ALCOHOL 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2105 BOONE ST. 29d. DATE SIGNED (Month, Day, Year) ▶APRIL 16,1995 111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

O.C.M.E.



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DHMH-16 Rev 1/89

> Approximata Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

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		219-16-81	98	1 M 2 □ F	70	YRS.	MONTHS	DAY	S HOURS	MM.	04	Day, Year)	25	Count	PLACE (State or Foreign RYLAND
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	2			105PIT	AL			GL	TEIN E	JURIN.	TE		A	MME	ARUNDEL
	DINE	MARYLAND	ANNE	ARUNDI	EL	10c. CIT				IIE					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
	3	10e. STREET AND NUMBER											10g. CIT	IZEN OF V	
									21	.061			U	.S.	A.
		1 Never Married XXI	Married	FORCES? 1	XYES 2	ARMED NO	13	If yes,	specify Cut	onn, Mexica	ns, Puerto I	l? (Specify Ye Rican, etc.)	e or No	Spec	
1	1 6	15. DECE	DENT'S EDUCAT	TION	16a.	DECEDENT'S	USUAL	OCCUPA	TION		16b	KIND OF BU	SINESS/IN		
					+)	life. Do NOT u	se retired.	.)		king		ELEC	CTRI	CAL	
9 6	5												Surname)		
70 .				RS SR.											
and the				3		196. MAILING	PA	ss (Stree GHA	M RC	PAD-	Route Numi	BURI	NIE,	p Code) MD .	21061
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		· 10	ary	2.1	outs	neng						FUNI	ERAL LEN	HON BURN	ME 21061
dical	T	23. PART i. Enter the dis	saases, la con	nplications tha	t caused tha	daath. Do r	not ante	er tha n	noda of d	ying, auc	h as card	liac or resp	iratory ar	rast,	Approximata
	1	IMMEDIATE CAUSE (Fine		it only ona cat	ISO ON BACH I	ina. 2				,					Onset and Dea
H, H		resulting in death)	→ a.,	He	mor	who	29	10	2	Shi	12/				5hv.
g (b)			-	DUE TO	(OR AS A CON	SEQUENCE OF	F): /	•	,	6.	-	11			1
THE STATE OF				DUE TO	(OR AS A CON	SEQUENCE OF	P):	10		4	5/2	IN			6 W
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othe		that initiated events		DUE TO	(OR AS A CON	SEQUENCE OF	F):								
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amy Inju		PART II. Other aignifican	t conditions	contributing to	daath but no	ot resulting	in tha u	indarly	ing cause	given in	Part i.	PERFOR	RMED?	24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
hows										_					1 YES 2 NO
				BUTE TO CA				_		CERTAII	N 🗆				N/A
E C		EXAMINER?		QSPITAL:					10)						
2 2			2				4 🗆 Nu	insing Ho		tasidence					
	- 10	Netural 5 🗆 P		(Month, D	wy, Ybar)			V	WORK?	□ NO	28d. DEŞ	CRIBE HOW I	NJURY OC	CURED	
		3 Suicide 8 C	ould not be	28a. PLACE O building,	F INJURY — At etc. (Specify)	home, farm, s	street, fac	ctory, of	fice				and Number	or Rural F	loute Number,
ELL							70/25 /						A	_	
) end manner ee stated.
RIAN	- 111			-	10)									THE STATE OF THE STATE OF
MPO		Contat	es A	E.A.									▶ 0	5/08	3/95
-		00. NAME AND ADDRESS OF	PERSON WHO C	OMPLETED CAUS	SE OF DEATH (I	TEM 27) (Type.	Print)								
	PORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BE COMPLETED BY PHYSICIAN: MEDICAL CEPTIFICAL	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	ARTIST 4. SOCIAL SECURITY NUMBER 219-16-81 90. FACILITY NAME (# not instead to the property of the property	4. SOCIAL SECURITY NUMBER 219-16-8198 9e. FACILITY NAME (If not institution, give street and the institution, give street and number in the institution, give street and number in the country marked and in the country marked	ARTIST C. BOWE 4. SOCIAL SECURITY NUMBER 219-16-8198 1 M 2 F 90. FACILITY NAME (IT not institution, give street and number) NORTH ARUNDEL HOSPIT NORTH ARUNDEL HOSPIT 100. STREET AND NUMBER 1 90.2 PAGHAM ROAD 11. MARITAL STATUS 1 Never Married 1 Never Married 1 Never Married 3 Widowed 4 Divorced WW 1. 1. MARITAL STATUS 1 Never Married 2 Never N	ARTIST C. BOWERS J. 4. SOCIAL SECURITY NUMBER 219-16-8198 1 Mm 2 F	ARTIST C. BOWERS JR. 4. SOCIAL SECURITY NUMBER 219-16-8198 5. SEX 219-16-8198 5. SEX 219-16-8198 6. AGE (in yrs. last birthday) 70 yrs. 80. FACILITY NAME (if not institution, give street and number) NORTH ARUNDEL HOSPITAL REBIDENCE OF DECEDENT 100. STATE 1	ARTIST C. BOWERS JR. 4. SOCIAL SECURITY NUMBER 219-16-8198 5. SEX 219-16-8198 5. SE	ARTIST C. BOWERS JR. 4. SOCIAL SECURITY NUMBER 2.19-16-8198 8. SEX 2.19-16-8198 8. SEX 2.19-16-8198 8. SEX 2.19-16-8198 8. SEX 2.19-16-8198 8. SEX 70 VRS. MONTHS DAY 8. CITY, TOWN OR LO RESIDENCE OF DECEDENT 90. COUNTY MARYLAND ANNE ARUNDEL 100. COUNTY MARYLAND 100. STREE AND NUMBER 1. MORTH ARUNDEL 1. MAS DECEDENT EVER IN U.S. ARMED PORCES? 1 (New York Or ALTE WW 11 1. MARYLAND 1. MARYLAND 1. MARYLAND 1. MARYLAND 2. DECEDENTS EDUCATION (Specify only highest produc completed) 1. MARYLAND 1.	ARTIST C. BOWERS JR. 4. SOCIAL SECURITY NAMBER 219-16-8198 5. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. SEX 219-16-8198 6. CITY, TOWN OR LOCATION GLEN BURN MARYLAND ANNE ARUNDEL 100. CONTY NAME OR LOCATION GLEN BURN MARYLAND ANNE ARUNDEL 100. STATE 100. COUNTY MARYLAND ANNE ARUNDEL 100. SEX 1902 PAGHAM ROAD 21 11 MARTAL STATUS 11 MARTAL STATUS 11 MARTAL STATUS 12 MARTAL STATUS 12 MARTAL STATUS 13 WISSONES (STORE AND OR CONTY) MARYLAND ANNE (First, Modific, Last) ARTIST C. BOWERS 21. SEX 21. SEX 22 MARTHOLOR OF DISPOSITION (Marthad) ARTIST C. BOWERS 22. MARTHOLOR OF DISPOSITION (Marthad) ARTIST C. BOWERS 23. PARTI I. Enter the diseases, broomplications that caused the death. Do not anter the mode of death once, or heart failure. List only one cause on each line. 100. PLACE AND DATE OF PURPLE (Final disease or condition) PARTI II. Cithar significant conditions 21. SEQUENTISH (MARTHAD ADDRESS) 22. MARTHOLOR OF DISPOSITION (Marthad) ARTIST C. BOWERS 23. PARTI I. Enter the diseases, broomplications that caused the death. Do not anter the mode of death once, or heart failure. List only one cause on each line. 100 DISPOSITION (MARTHAD ADDRESS) 23. PARTI II. Cithar significant conditions 24. DOWNERS 24. DOWNERS 25. SEX 26. CITHAD OF DISPOSITION (MARTHAD ADDRESS) 26. MARTHOLOR OF DISPOSITION (MARTHAD ADDRESS) 27. MARKED OF PARTHAD (MARTHAD ADDRESS) 28. MARTHAD OF PARTHAD (MARTHAD ADDRESS) 29. MARTHAD OF PARTHAD (MARTHAD ADDRESS) 20. MARTHAD OF PARTHAD (MARTHAD ADDRESS) 20. MARTHAD OF PARTHAD (MARTHAD ADDRESS) 20. MARTHAD OF PARTHAD (MARTHAD ADDRESS) 21. SEQUENTISH (MARTHAD ADDRESS) 22. MARTHAD ADDRESS (MARTHAD ADDRESS) 23. PARTI I. Enter the diseases, broomplications that caused the death. Do not anter the mode of death address of the marthad address of the marthad address of the marthad address of	ARTIST C. BOWERS JR. 4. SOCIAL SECURITY NUMBER 21.9-16-8198 5. SEX 70 VPG. 4. SOCIAL SECURITY NUMBER 21.9-16-8198 5. SEX 770 VPG. 5. SEX 770 VPG. 5. SEX 770 VPG. 5. SEX 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 5. SEX PVG. 770 VPG. 6. STATE SEX PVG. 770 VPG. 6. STATE SEX PVG. 770 VPG. 6. STATE SEX PVG. 770 VPG. 77	ARTIST C. BOWERS JR. 4. SOCAL SECURITY HUMBER 2. 1. GEORGE 1983 5. SEX 70 VIB. WAY 1. SOCAL SECURITY HUMBER 2. 1. GEORGE 1984 5. SEX 1. SEX	ARTIST C. BOWERS JR. 1. SOCIAL SECURITY NUMBER 21 9 - 16 - 8198 1. W w P AGE (by yn. bar birthody) FUNCTO 1 1240 1800 1	ARTIST C. BOWERS JR. SOCIAL SECURITY HAMBER S. SEC 1.00 T. SEC T. ADD (The year has before) T. SEC T. ADD (The	ARTIST C. BOWERS JR. ARTIST C. BOWERS JR. ARTICLE PRINCIPLE SUBSTITUTE SUB

CONSTANTINE J. PADUSSIS M.D. 7310 RITCHIE HWY.GLEN BURNIE, MD.

32. REGISTRAR'S SIGNATURES

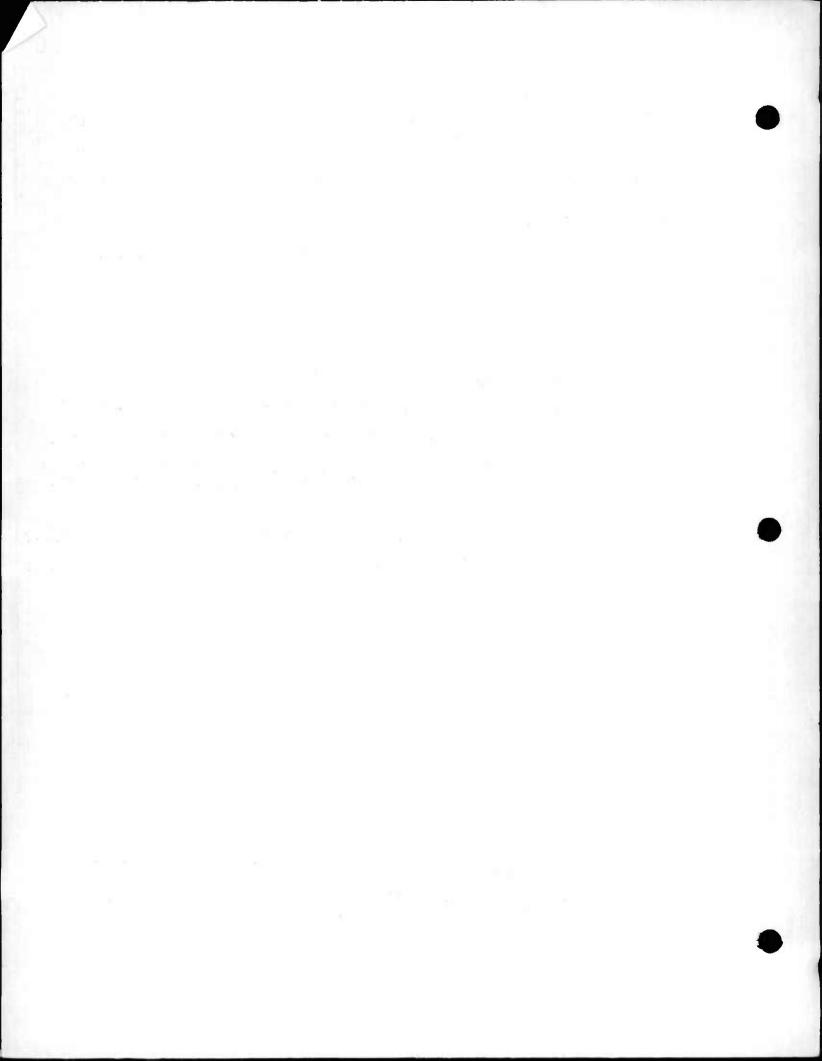
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

FOR STATE REGISTRAR

31. DATE FILED (Month).

0 9 1995

1. DECEDENT'S NAME (First, Middle, Lest)

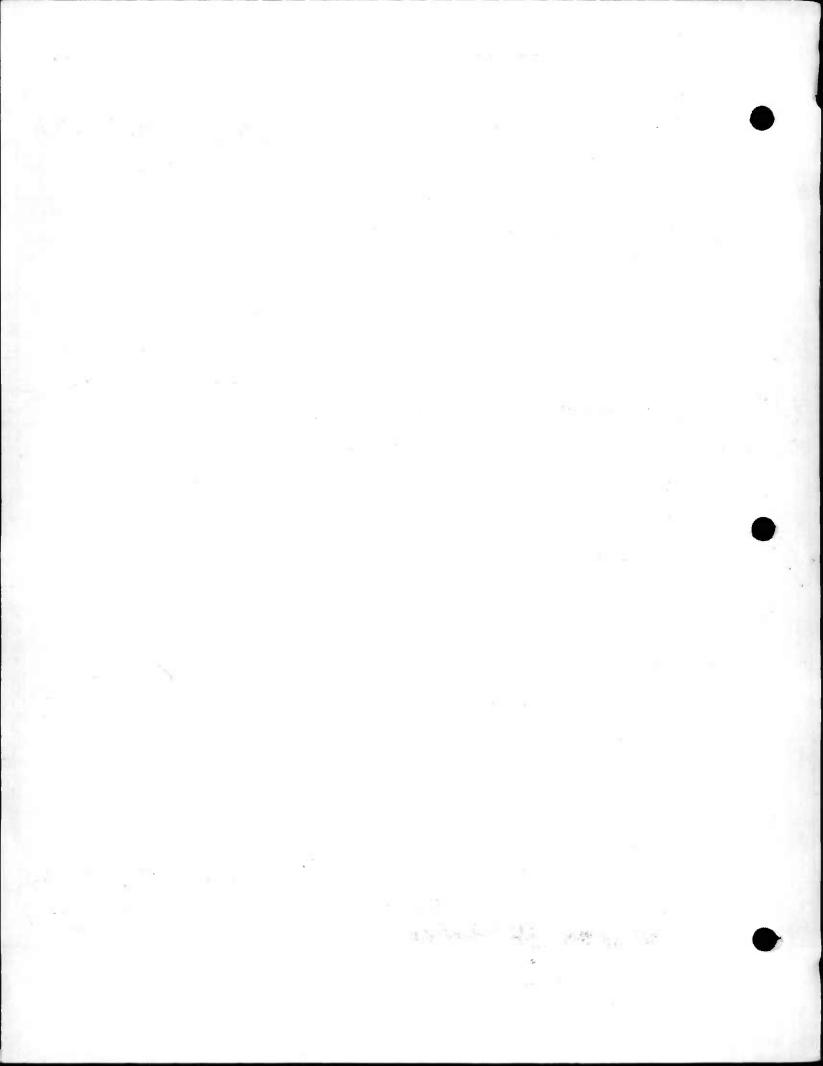


• 6 may be retained by the hospital or attending physician. ector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

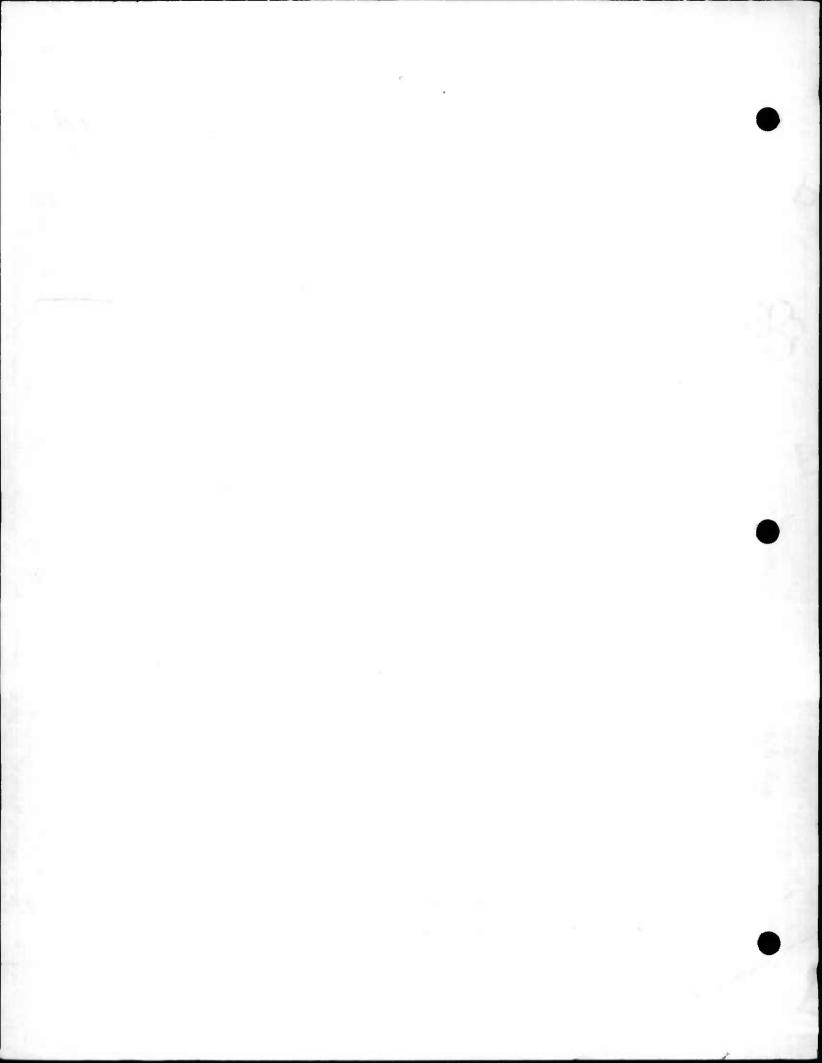
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner m

1	Item # 18 Film # G 723 5	5-9-95 N.A. Pe	r fune	eral Home					95	3991
	1 - STATE REGISTRAR	STATE OF MARYL		DEPARTMENT ERTIFICATI			MENTAL			
	1. DECEDENT'S NAME (First, Middle, Last)			MINIOAL	2 01	DEATH		REG. NO.		3. TIME OF DEATH
	JACK	Biook	<				MONTH		199	EAR III - A
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last	birthday) IF UNDER	t YEAR	IF UNDER 24 HRS.	7. DATE O	# BIRTH	8.	BIRTHPLACE (State or Foreign
	157-26-3661	M2 OF 8	5	YRS, MONTHS	DAYS	HOURS MIN.	(Month)	04-0		Country) PC
	9e. FACILITY NAME (If not institution, give stre	reet end number) 111	Acai	deminos. cit	, TOWN O	R LOCATION OF DI			9c. COUNTY	OF DEATH
<u>د</u>	Frederick V	ILLa Nurs	me (who if	247	hmme	2	1228	64	1 bx
ਰਿ	RESIDENCE OF DECEDENT	7.00.0	7	7101 /-	110	1 1 11VI DE	, ,	1001	10/1	C/ 0 ·
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY, TOWN	OR LOCAT	ION				10d. INSIDE CITY LIMITS?
		ltimore		Cato	onsvi					1 🔀 YES 2 🗌 NO
A I	711 Academy Road				101,	21228			10g, CITIZEN	OF WHAT COUNTRY?
FUNERAL										USA
5	11. MARITAL STATUS 1	12, WAS DECEDENT EVER IN FDRCES? 1 X YES	2 NO			ENDENT OF HISPAI ecity Cuben, Mexico			or No- 14.	. RACE — American Indian, Black, White, etc.
B	3 ☑ Widowed 4 □ Divorced	IF YES, GIVE WAR OR D	ATES			2 XNO Specif				Specify:
ED	15. DECEDENT'S EDUC	WW II	18e. DEC	CEDENT'S USUAL O	CCUPATIC	MAJ .	1 16h	KIND OF BUSI		White
ETE	(Specify only highest grade of	completed)	(Giv	ve kind of work done Do NOT use retired.)	during mos	st of working	100,	KIND OF BUSI	NESS/IMDG2	THY
PL	Elementary/Secondary (0-12)	College (1-4 or 5+)	P	ostal Wo	rker			US	Gove	rnment
COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, M			LIMETT
	Sam Brooks					Phy11			Sadie	Unknown
BE	19e. INFORMANT'S NAME (Type/Print)		19b.	. MAILING ADDRES	S (Street a					
유	Phyllis Beskins	Beskin		030 Ocea						00)
	20e. METHOD OF DISPOSITION	201	h PLACE AL	ND DATE OF DISPOS	SITION /No	me of	DATE	200 1.00	ATION - CITY	y or Town, State
	Buriel 2 ☐ Cremetion 3 ☐ Remove 4 ☐ Donetion 5 ☐ Other (Specify)	wal from State	netery, crem	rarat Ce	mote	ry May	0 0	5 Sino	1 0	NT \77
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	16	22.	NAME AN	ID ADDRESS OF FA	ン・ノ VCILITY	JELINE	Lawii,	N.Y.
	1 D+ X/). A.A. M.		5	terl	ing Ashi	ton F	uneral	Home	
<u>.</u>	Jun & C	1000 110	6017	- 1 -	200	1 1 1		-	-	M.1- 21222
	23. PART I. Enter the diseesea, or co shock, or heart fellure. L	omplications that cause	d the dea	ith. Do not anter	the mo	de of dying, auc	h aa card	ac or raspir	atory arrest	Approximate
	IMMEDIATE CAUSE (Final	1		0)	1				Onset and Death
	disease or condition resulting in deeth)	Cancer	1 6)+ t	he	Pal	ncr	eas		IMONTH
		DUE TO (OR AS	A CONSEO	UENCE OF):					3	
Z	Sequentially list conditions, b.									
ERTIFICATION	If any, leading to immediate	DUE TO (OR AS A	A CONSEC	UENCE OF):						
2	CAUSE (Disease or Injury									
	thet initiated events resulting in deeth) LAST	DUE TO (OR AS A	A CONSEO	UENCE OF):						
: 浜	d d	l								
0	PART II. Other significant conditions	s contributing to deeth !	but not re	suiting in the w	nderlying	z ceuse given in	Part I.	24s. WAS AN /	WITOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL	ASCITES			Alle and a second	10			PERFORE	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 TYES 2	NO	OF DEATH?
	DID TOBACCO USE C	ONTPIRITE TO	CALIS	E OF DEAT	ru v	ES I NO				1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED/TO MEDICAL	ONINBUIL IO	CAUS	E OF DEA						
[I	EXAMINER?	HOSPITAL:		ОТНЯ	A:	ACE OF DEATH (Ch				
1×S	1 YES 2 NO	1 Inpatient 2 ER/Out	patient 3 (_	e 5 Residence	_			
4 L U	1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)		28b, TIME OF INJURY		RK?	26d. DEŞ	CRIBE HOW IN	JURY OCCUR	RED .
à	2 Accident Investigation	00 01 10E 05 IN HER		PM .		ES 2 NO				
<u>a</u>	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	f — At non icify)	ne, ferm, street, fac	tory, office	•	28f. LOCA City o	ATION (Street et or Town, State)	nd Number or	Rural Route Number,
릴		CIAN: To the best of my know								
COMPL	one) 2 MEDICAL EXAMINER	R: On the besis of examination	on end/or In	westigation, in my	opinion, de	eath occured at the	time, date	end place, end	due to the c	euse(e) end manner es stated.
U U	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU	MBER		29d. DATE S	IGNED (Month, Day, Yeer)
i ii		MAR	1	10		028	23	6	>MC	2 × 1995
		COMPLETED CAUSE OF DE	TATUL OTTO	Am (*		1	1		- 10	7 0,110

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	_	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMI	ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.		
		ni. ~ 1531	Beamon 5. SEX 6. AGE (In yrs. lest birthday) FU 1 M M 2 F YRS. MONT	NDER 1 YEAR IF UNDER 24 HRS. FMS DAYS HOURS MIN.	2. DATE OF OEATH DAY MONTH DAY 7. DATE OF BIRTH (Month, Day, Yang)	1793	TIME OF OEATH ACE (State or Foreign
1, 2, 3 should	стоя	98. FACILITY NAME (If not institution, give street of the STEEDENCE OF DECEDENT	ot and number) OS prtz-1 96.	CITY, TOWN OR LOCATION OF DE	CD7 -7	9c. COUNTY OF DEAT	LH A A A A
permit. Pages	DIRE	10e. STATE 10b. COUNTY	A 10c. CITY May	WN OR LOCATION		1	d. INSIDE CITY LIMITS? YES 2 NO
. .	FUNERAL	602 Louden	AUL 12. WAS DECEDENT EVER IN U.S. ARMEO	13. WAS DECENDENT OF HISPAN	29	10g. CITIZEN OF WHA	· A.
5-0 anding as the	B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☑ YES 2 ☐ NO /2 IF YES, GIVE WAR OR OATES	If yes, specify Cuban, Mexical 1 VES 2 NO Specify	n, Puerto Rican, etc.)	Black, W	American Indian, Thite, atc.
D 21 spital or ed for u	COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor		lone during most of working ed.)	Calvert	Destil	lley
YLA by the be det	l w l	12_EATHER'S NAME (First, Middle, Last) ONCES ROBUE	elt Beamon	18, MOTHER'S NAI	ME (First, Middle Maiden Su	irname)	
ay be retained bage 5 should be notified	TO B	199 INFORMANT'S NAME (Type/Print) Lhwa m.	Sherad 4709	RESS (Street and Number or Aural F Sayer Ave	- Baltui	State, Zip Code) mol 2/2	129
6 may ctor, pa		30/ METHOD OF DISPOSITION Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	- Carison	POSITION (Name of types Vet	Milas OL	NILLS M	state 116, nd
SAL r death re fune al.		21. SIGNATURE OF FUNERAL SERVICE LICENT	Wane	March F. H. W 4300 Webes	L Ave	,	
be executed within 24 cian and completely filly filly to burial, cremation, remarked, the raumatic event, the	ICATION	23. PART I. Enter the diseases, or comshock, or heart fellure. Lia IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF):		n ea cerdiec or reepiral	tory erreat,	Approximete interval Between Onset and Daath 2 days
the death certificate the attending physical Mental Hygiene principle.	CERTIFI	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):				
records equires that the sen signed by the of Health and M though the shows any Infu	MEDICAL	Chronic renal fail	uni, Hypervension,	Sergere des	PERFORME THE 2	NO OF	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
N: The law ficate has be State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE OF DEATH YES 28. PLACE OF DEATH (Ch	eck only one)	1 🗆 📗		
SICIAN: The certificate in the State	PHYSI		Impatient 2 ER/Outpetient 3 DOA 4 D	HER: Nursing Home 5 - Residence	8 Other (Specify) 28d. OEŞCRIBE HOW INJI	HOV OCCURED	
ON OF OR OF OF OF OF OF OF OF OF OF OF OF OF OF	ВУ Р	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY	WORK? 1 YES 2 NO	200. VEQUIDAE HOW	UNI OCCURED	
OR ATTENDIN DIRECTOR: Af hours after de Item 28 Is I	ETED	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY — At home, farm, street, building, atc. (Specify)	factory, offica	28f. LOCATION (Street and City or Town, State)	f Number or Rural Route	Number,
보 보 전 노	COMPL	One) 2 MEDICAL EXAMINER: C	AN: To the best of my knowledge, death occurred at to the basis of examination and/or investigation, in r				d manner as stated.
TO THE HOSPIT TO THE FUNER De filed within T	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER .	igu M.D.	29c. LICENSE NUM	162 2	DATE SIGNED (MO May -	6-95
+1		Samih Jarjou	COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 12 900 Caton av E	St. Agnes 1	Hospital	BALTIMO	PE, MD. 21229
		31. DATE FILED (Month, Day, Year) MAY () 9 1995	32 REGISTRAR'S, SIGNATURE				



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

		1. DECEDENT'S NAME (First	, Middle, Last)							OF DEATH			3. TIME OF OEATH
		FREDERICK		CHARLE	S	BA	ŒR		MON1	May 3		YEAR	10:45 am M
		4. SOCIAL SECURITY NUME		5. SEX		yrs. last birthday			7 DATE	OF BURTH		8. BIRTHE	LACE (State or Foreign
Þ		214-03-795		1 💢 M 2 🗆 F	86	YRS.	MONTHS D	WS HOURS MIN.	APR	.23, 1	909	Mary	land
3 should	-	Sa. FACILITY NAME (If not in						WN OR LOCATION OF	DEATH			TY OF DE	ATH
2	DIRECTOR	Saint Jose		fical Center			T	owson, Mar	yland		В	altimo	re
÷ ÷	E C	10a. STATE	10b. COUNT	Y		10c, C	ITY, TOWN OR L	OCATION					10d. INSIDE CITY
2	뜸	Maryland	Balt	imore Cou	inty		hervil						LIMITS? X
permit. Pages	AP.	10e. STREET AND NUMBER						10f. ZIP COOE			10g. CITIZ		AT COUNTRY?
ist.	띮	109 Belmore	Road					21093				U.S.	
215-0020 attending physician. se as the burial-transit	FUNERAL	tt, MARITAL STATUS	27	12. WAS DECEDEN FORCES? 1			13. WAS	DECENDENT OF HISPA	ANIC ORIGI	N? (Specify Yes	or No-	14. RACE	- American Indian,
000 pp pp pp pp pp pp pp pp pp pp pp pp	BY	1 Never Married 2 X 3 Widowed 4 Divo	•	IF YES, GIVE W		ES XNO		s, specify Cuban, Mexic YES 2 X NO Spec		Rican, atc.)		Specify	White, atc.
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or aff		(Specify only	y highest grade	completed)		18a. DECEDENT (Give kind o life. Do NOT	f work done durir	PATION og most of working	168	. KIND OF BUS	SINESS/INOU	JSTRY	
D Spital	=	Elementary/Secondary (0	F12)	College (1-4 or 5 d	')	Accoun			(Club,	oriva	to	
AND 212- the hospital or att detached for use once.	COMPLET	17. FATHER'S NAME (First, M.	liddle, Last)			ACCOUNT	Lait	18. MOTHER'S N				LE	
# 5 4 F	ш	Charles And	lrew B	aker				Elizah		M.	Comemay	Par	r
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.	10 B	19a, INFORMANT'S NAME (7				19b, MAILIN	IG AODRESS (St	reet and Number or Rura	l Route Num	ber, City or Tow	n, State, Zip	Code)	
5 90 5 90 5 90 5 90 5 90 5 90 5 90 5 90	🏲	Audrey M.R.				109 F	elmore	Rd. luthe	ervil	le, Man	rylan	d 210	093
ALTIMORE, I death. Page 6 may be e funeral director, page 11.		20a METHOD OF DISPOSITI	ION on 3 🗆 Ren	oval from State	20b. P	PLACE AND DAT	E OF OISPOSITIO		DAT		CATION — C		
MO directi		4 Donation 8 Other	(Specify)		Du	Laney V		MAY		Lutl	hervi	lle,	Maryland
H a m		21. SIGNATURE OF FUNERAL	L SERVICE LIC	CENSEE				E AND ADDRESS OF F		1d How			
. 0 = 0		100	no	ocar 1				00 York Ro				rv1a	nd 21212
C 12 at		23. PART I. Enter the di	seeses, or	complications that List only one cau	t caused t	the deeth. Do	not enter the	mode of dying, au	ch sa cen	diac or respi	ratory arre	at,	Approximate
		IMMEDIATE CAUSE (Fin		List Only One Cau	ise on eac	on line.							Onset and Death
- P. # =		disesse or condition resulting in desth)	→	CEPEBF	PAL HE	EMORRI-	AGE						2 DAYS
B 2 - 6				DUE TO	(OR AS A C	CONSEQUENCE	OF):						
× 10 _ =	NO N	Sequentially list conditi		b	10D AC A C	CONSEQUENCE	200						
or be	CERTIFICATION	If any, lesding to immed cause. Enter UNDERLY!		502 10	(OH AS A C	ONSECUENCE	OF):						
Phy phy	윤	CAUSE (Disease or Inju that initieted events	ry	c. DUE TO	(OR AS A C	ONSEQUENCE	OF):						
A - C - A 1	F	reaulting in death) LAS	т	d.									
0 0 0 5		PART II Other elanifica	nt condition	e contribution to	donth had		f . At						
1 2 T A D T	EDICAL	PART II. Other significa			death but	not reaulting	in the under	lying cause given in	n Part I.	24a. WAS AN PERFOR		1	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
ECORD luires that the signed by the Health and North and North and North and North and North and North and North and North and North and North and North and North and North and North and North and North Annie and North An		PULMONA		THOEMA						t 🗌 YES 2	No	(COMPLETION OF CAUSE OF DEATH?
# 0 0 0 m	Σ	DID TOBACCO U	SE CONIT	DIDLITE TO CA	LICE OF	DEATH V	TC D NO	T INCEPTAGE				1	TYES 2 NO
13 kg s a L	AN	25. WAS CASE REFERRED TO		KIBUIE IU CA		L PLACE OF DE			ИП				
SICIAN: The certificate h the State [4, or Item	PHYSICIAN:	EXAMINER?		HOSPITAL:			OTHER:		2 0 00				
Sicia Sicia certif	Ŧ	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TI	ME OF 28c	Home 5 Residence	T	CRIBE HOW II	IJURY OCCI	JRED	
NG PHYS frer this cath with	ВУР		Pending Investigation	(Month, De	my, Year)		JURY M 1	WORK?					
J 5 4 5	ED B	3 Suicide a	Could not be	28s. PLACE Of building.	F INJURY -	- At home, Jerm,	street, lactory,	offica	281. LOC	ATION (Street e	nd Number o	or Rural Ro	ute Number,
DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is mai	- I	4 Homicide	determined						City	or lown, Siele)			
L OR / L DIREC Phours	2	29a. CERTIFIER 1	IFYING PHYSI	CIAN: To the best of	my knowled	ige, death occur	red at the time,	date and place, and du	a to the cau	rse(a) and man	ner an atate	d.	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLE							on, death occured at the					and manner as stated.
E HO	BE C	295. SIGNATURE AND TITLE	OF CERTIFIED	11				29c. LICENSE NU	IMBER		29d. DATE	SIGNED (Angth, Day, Year)
TO THE HOSPIT TO THE FUNER De filed within 7		Ju	reix	104	A	2)		D 0412	16		D 5	131	95
13	2	30. NAME AND ADDRESS OF									-		
14		ALBERTO J					TOWSO	N, MARYLAN	AD 515	204			
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		HILL O . 100	U										i

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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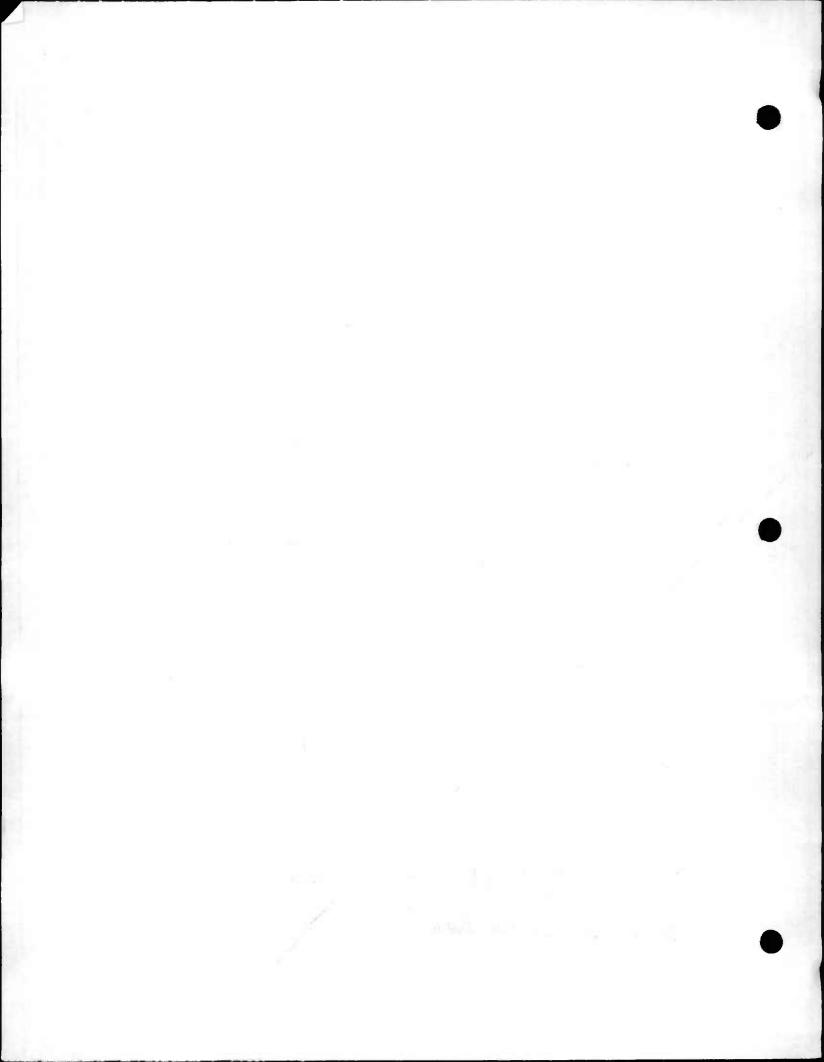
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ALBERTO J DIAZ MID 7820 YORK HOAD TOWSON, MARYLAND 21204

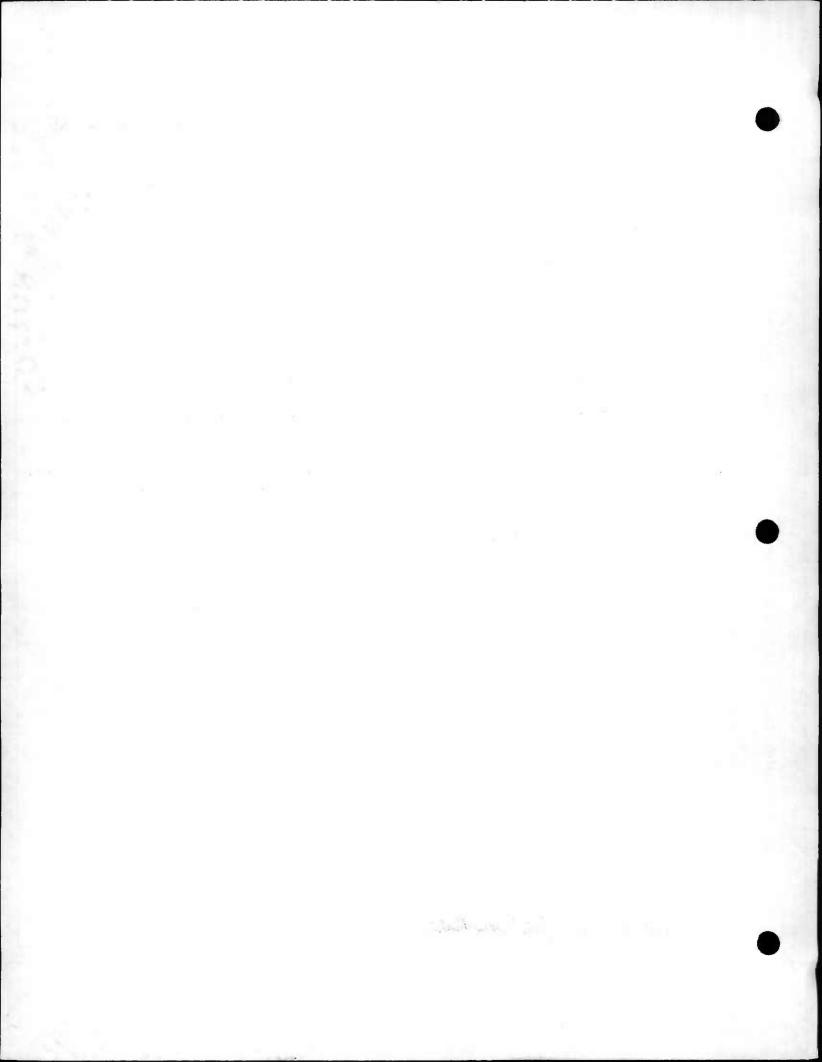
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		1 - STATE REGISTRAR	SIATE UF MA			ICATE				MENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Las	0					<u></u>		2. DATE OF DEATH		EAR 3.	TIME OF DEATH
		Charles Elwo								May	6, 199	95	8:30 A.
		215-03-7801	5. SEX 8.	79 79	YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Country)	ACE (State or Foreign
Should		90. FACILITY NAME (If not institution, give	Δ			9b. CITY,	TOWN C	R LOCATION	ON OF DEA	April 30	, 1916		cyland
2, 3,	0 B	514 Castle Driv	e, Apt B			В	alti	more	2		Balt	imor	e County
Des 1.	DIRECTOR	10e. STATE 10b. COUN			10c, CIT	Y, TOWN O	R LOCAT	ION					d, INSIDE CITY
permit. Pages			imore Coun	ty	Α	Innes	lie					1	LIMITS?
	RAL	10s. STREET AND NUMBER					101	ZIP CODE	_		177		T COUNTRY?
ician.	FUNERAL	514 Castle Dri	.Ve, Apt B	EVER IN U.S. AR	MED	13. \	MAS DEC	212		C ORIGIN? (Specify Ye		USA	American Indian.
21215-0020 al or attending physician. for use as the burla-transit	BY FI	1 Never Married 2 Merried 3 Wildowed 4 Divorced		YES 2 N			f was and	which who	n, Mexican Specify:	Bueste Bleen stell	S OF RO-		Thite, atc.
		15. DECEDENT'S EC	DUCATION	16a DF	CEDENT'S	USUAL OC					ISINESS (NIOUS	TEN	White
212	COMPLETED	(Specify only highest gra	de completed) College (1-4 or 5+)	(Gi	ve kind of a Do NOT us	work done o	during mos	st of workin	g	16b. KIND OF BU	SINESS/INDUS	THY	
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MARYLAND 212- retained by the hospital or att 5 should be detached for use notified at once.		17. FATHER'S NAME (First, Middle, Last)	+1							NE (First, Middle, Meider			
MARY retained b 5 should t	BE (John Edward Ba 194. INFORMANT'S NAME (Type/Print)	thgate	198	MAILING	ADDRESS	(Street e			Theresa H		rde)	
	임	Mrs. Marietta	M. Bathgat							ltimore,			
BALTIMORE, I ter death. Page 6 may be the funeral director, page wal.		20e_METHOD OF DISPOSITION 1	movel from State	20b. PLACE A	ND DATE (OF DISPOSI	ITION (Na	me of		DATE 20c, LO	OCATION City		State
Page 6 direct		4 Donation 5 Other (Specify)	GENSEE	IMD Ve	tera	ns Ce			SON		rrison,	Mar	yland
ALTIMO death. Page 6 tuneral directo i. examiner mu		Martin D.	awson							efeld Hom		- 01	0.1.0
# > F 3		23. PART I. Enter the diseases, o		aused tha de	nth. Do r	not antar	SUU the mor	YOTK	ng. auch	d, Baltim	ore, M	<u>D 21.</u>	212 Approximate
		shock, or heart failure IMMEDIATE CAUSE (Final	. List only one cause	on each line.							matory arroad	,	intarval Between Onset and Daath
tely mati		disease or condition reaulting in death)	Arus.	e Y	سكل	mo	7	5	Lon	-u			
coecuted within and completely burial, cremati	_	_	DUE TO (OI	R AS A CONSEC	UENCE O	F):	0	5	0.	-			
P.O. BOX 68760 ath certificate be executed with tending physician and comple al Hygiene prior to burial, crer or other traumatic even	CERTIFICATION	Sequantially list conditions, if any, leading to immediate	b. OUE TO (OI	R AS A CONSEC	UENCE OI	F):				wa			
BOX ficate be physician ne prior t	ICA	cause. Enter UNDERLYING CAUSE (Disease or Injury	c										
i, P.O. Be leath certificate attending physiontal Hygiene pri y, or other to	RTIF	that initiated events reaulting in death) LAST	DUE 10 (OF	R AS A CONSEC	UENCE OI	F):							
DS, P. the death of the attend Mental H injury, or		DART II Other algorithment condition	d.										
M = 55 -	MEDICAL	PART II. Other algnificant condition	na contributing to da	ath but not re	eaulting i	n tha un	dariying	cauaa g	iven in P	PERFO	RMED?	AW	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE
w requires the been signed of. of Health a shows any	MED						_			1 TYES	5 NO	OF	DEATH?
AL RI e law req has been Dept. of		DID TOBACCO USE CON	TRIBUTE TO CAUS	SE OF DEAT	TH YE	S D N	10 🗆	UNC	ERTAIN		/	''	YES 2 NO
一年 書 書 二	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER							
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	ВУ Р	Natural 5 Pending	(Month, Day,			URY M	WOR			200. DESCRIBE HOW	INJUNY OCCUM	EU	
0 0 0 0		3 Suicide 6 Could not be	28e PLACE OF II	NJURY — At hor c. (Specify)	ne, farm, a	rireet, facto	ory, office			28t. LOCATION (Street City or Town, Stete	end Number or	Rural Route	Number,
DIVISI OR ATTEN DIRECTOR: hours after Item 28 I	ETE	4 Homicide determined								only or lown, otelo	7 4		
7 7 7 -	COMPL		SICIAN: To the best of my										
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If		29b. SIGNATURE AND TITLE OF CERTIFI	NER: On the basis of sxam	minarion end/or is	TVestigatio	n, in my op	olnion, de	_					
O THE O THE e filed	BE	Bounk 7	orlow	, un	0			29c. LICE	NSE NUME	SER TOTAL	29d. DATE SI	GNED (Mo	onth, Day, Your)
1/	유	30. NAME AND ADDRESS OF PERSON W						का व		-	3	0	* 1
0		Benjamin K. Yor	koff, M.D.	, 7401	Osle	r Dr	ive,	Tow	son,	Maryland	21204		
		MAY U 5 1995	32 REGISTRAR'S	CONSTURE									
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10		FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL	HYGIEN				
			Seroma 1	30911,	Sr.		2. DATE MONTH			EAR	TIME OF DEATH	М
pin		4. SOCIAL SECURITY NUMBER 216-20-7003	1 X M 2 - F	n yrs. lest birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	July	OF BIRTH , Day, Year) / 26.	1925	BIRTHPLA Country) Mary		
1, 2, 3 should	CTOR	96. FACILITY NAME (If not institution, give a St. Agnes Hospi RESIDENCE OF DECEDENT				on Location of bi	EATH		9c. CQUNT		Н	
Pages	DIRE	Md. H	oward		Y, TOWN OR LOCA OTSEV	TION					1. INSIDE CITY LIMITS?	
an. transit permit.	FUNERAL	7041 Cedar Ave.				f. ZIP CODE 2122				N OF WHAT	COUNTRY?	
215-0020 attending physician. ise as the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED 2 NO NTES	If yes, sp	CENOENT OF HISPAI Hecity Cuben, Mexica 5 2 X NO Specifi	in, Puerto F	? (Specify Ye	s or No 14	RACE — Black, WI Specify:	American Indian, hile, sic. White	
, o n	LETED	15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of v		ON ost of working	16b.		SINESS/INDUS	TRY		
the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	N/A[Accour	ntant	18. MOTHER'S NA	ME (First, M	Railr Modde, Melder				
8 8 6 Z	BE	Francis J. Bea	11, Sr.	10h MAII ING	ADDRESS (Street	Ida Sm		China Su	2 - 1 - 2 - C	7.		
be ret	5	Francis J. Bea	11, III	1		Ave. Do		-				
MORE rector, pa		20e. METHOD OF DISPOSITION 1 Burial 2 Cremellod 3 Rem 4 Donation 5 Other(Specify)	oval from Stale cem	PLACE AND DATE O	DE DISPOSITION /N/		OATE	200 10	CATION CIL	or Town,	State	
ALT death. funera		21. SIGNATURE OF TUNERAL SERVICE LIC	L. Kouf	many	Gary 5695	NO ADDRESS OF FA L. Kaufm Main St.	an Fu . Elk	neral ridae	Home	of E	lk., Inc	-
both a the state of the state o		IMMEDIATE CAUSE (Finsi	E. Teta Static DUE TO (OR AS A	ich lina.					iretory arres	t,	Approximata Interval Betwee Onset and Das	
D.S., P.O. BOX 6876 the death certificate be executed the attending physician and com d Mental Hygiene prior to bunal, injury, or other traumatic or	CERTIFICATION	Sequantisily list conditions, if sny, iseding to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с	CONSEQUENCE OF							lwk	
< % € % X	MEDICAL	PART II. Other significant condition	e contributing to death be	ut not resulting i	n the underlyin	g causa given in	Part I.	24a. WAS AN PERFOI 1 TYES	RMEO?	AVA COI DF	RE AUTOPSY FINDING ILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
AL KE he law requ has been s Dept. of l		DID TOBACCO USE CONT					N 🗆			'	YES 2 X NO	
SICIAN: The certificate had the State D	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 (NO	HOSPITAL:	28. PLACE OF DEAT	OTHER:	ne 5 🗆 Residence	8 C Other	(Specify)				\exists
NG PHYSICIA fler this certificath with the marked, or		27. MANNER OF OEATH 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ	JURY AT DRK?			INJURY OCCUP	NEO		\exists
TTENDI TTOR: A after d	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Special Control of the Contro	— At home, farm, s		YES 2 NO	28f. LOCA City o	ATION (Street or Town, State)	and Number or	Rural Route	Number,	\dashv
SPITAL OR AT VERAL DIRECT Nin 72 hours a VT: If item 2	COMPLETE		CIAN: To the best of my knows							suse(s) sno	I manner as stated.	
TO THE HOSPITAL OF THE FUNERAL D DE FIED WITHIN 72 ho	O BE C	296. SIGNATURE AND TITLE OF CERTIFIES	rach. s	3 . HD		29c. LICENSE NUN D455			29d. DATE S		nth, Day, Year)	7
()+1		30. NAME AND ADDRESS OF PERSON WH	1, 900 cator	AU.	e Ba	Hermon	e Mi	D - 21.	229.			
		MAY 0 9 1995	32 A REGISTRAR'S CONT	7.71								



Jeath. Page 6 may be retained by the hospital or attending physician, funeral director, page 5 should be detached for use as the bunal-transit hours after death. the and physician requires that the death certificate has been The law OR ATTENDING PHYSICIAN: After DIRECTOR: HOSPITAL 뿔 2

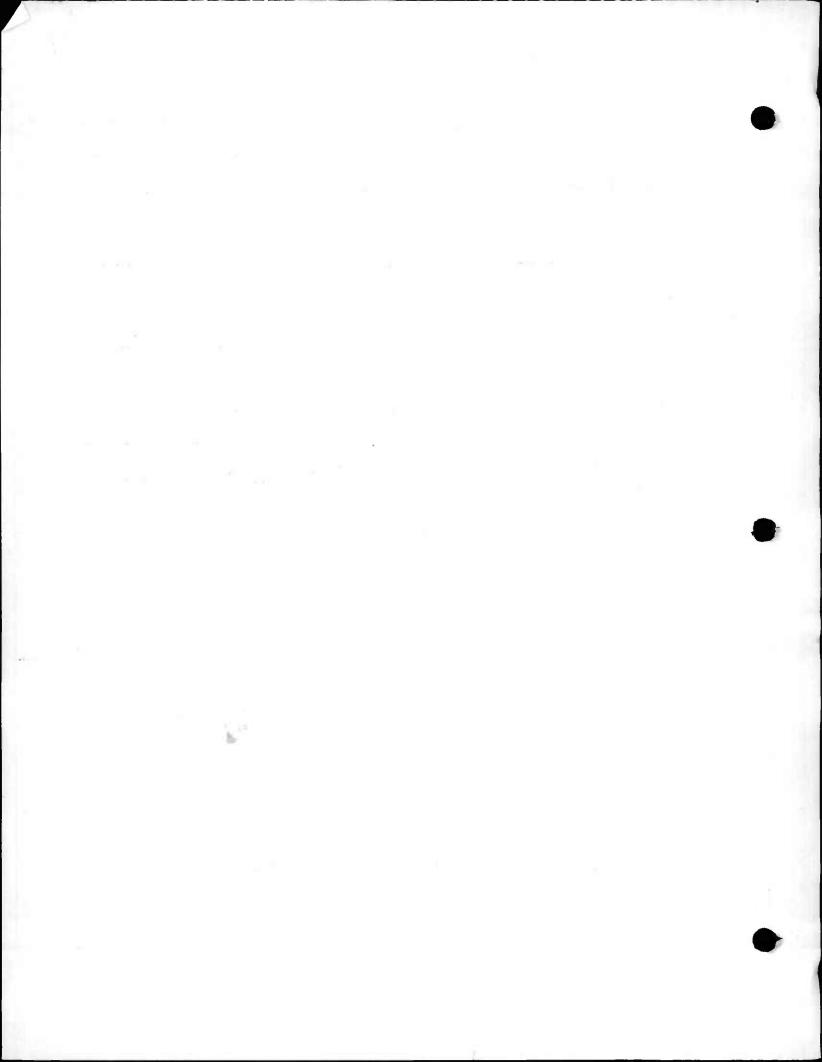
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH MAY 5, CHARLES 1995 BUTLER 19:36 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 XM 2 F MONTHS DAYS HOURS 579-10-0967A 07 Washington, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH THE JOHNS HOPKINS HOSPITAL DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland NA Baltimore City XXYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3030 McElderry Street 21205 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY Specify: 3 Widowed 4 Divorced 4/43 - 4/46Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+j 12 NA Manufacturing Machinist once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at Vincent Butler BE Aline Haley 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Helen Butler 3030 McElderry St. Balto, MD 21205 be 20g METHOD OF DISPOSITION
1 A Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Garrison Forest Cem. 4 Donation 5 Other (Specify) 5/11/95 Owings Mills, MD examiner 21. SIGNATURE OF FUNERAL SERVICE MICHAELE 22. NAME AND ADDRESS OF FACILITY
Unity Funeral Home 108 W. North Ave. Balto, MD 21201 and completely filled in by the burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition Myocordia interction a 40-15 reaulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) Colonory ortero 2 years CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 the atten 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THE 1 TES 2 AND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one The The State HOSPITAL: OTHER: 1 ES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 6 27. MANNER OF DEATH 28a, DATE OF INJURY this co 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Natural 5 Pending 1 YES 2 NO death BY 2 Accident Investigation 26e. PLACE OF INJURY - At home, ferm, street, fectory, office 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) .55 COMPLETED 6 Could not be after 28 4 Homicide HOURS Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. TO THE FUNERAL D be filed within 72 ho IMPORTANT: If Its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mennar as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER MOS (4 BE 29d. DATE SIGNED (Month, Day, Year) 5/9/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. WEIRE TWEET (aic 31. DATE FILED (Month, MAY 0

A James Santall

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within	TO THE BLINEBAL DIRECTOR. After this certificate has been signed by the attendion physician and completely files
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a management of the continuous properties.

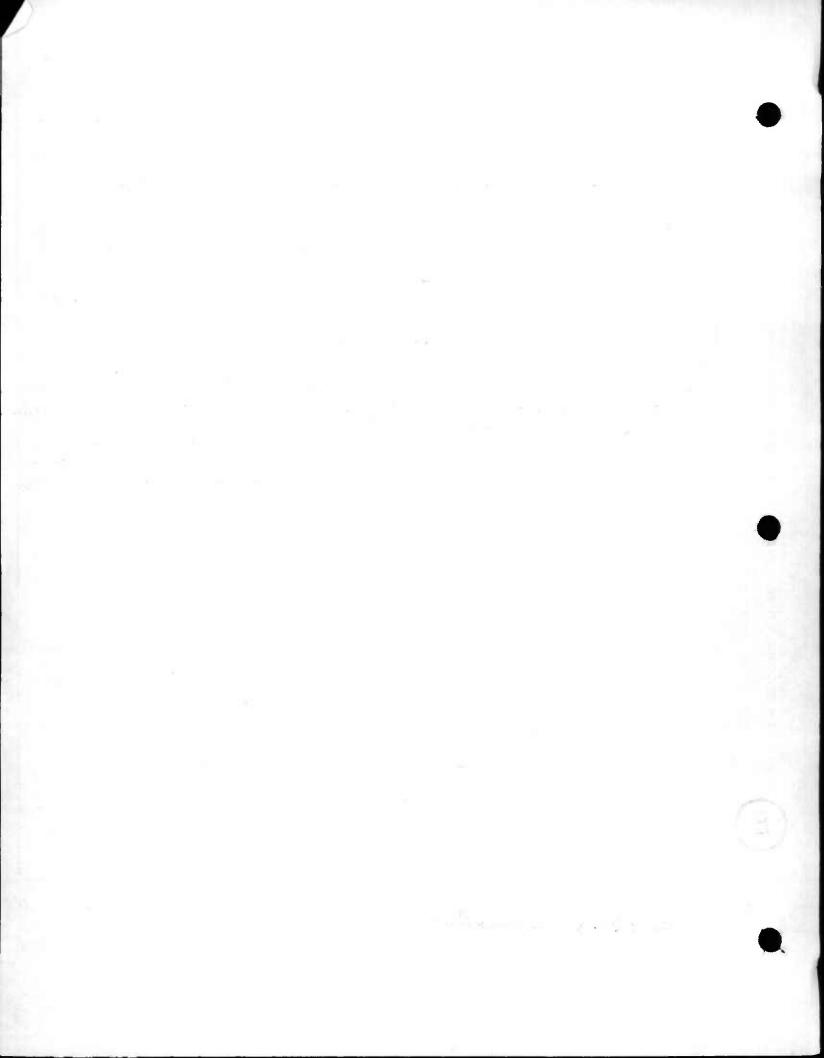
		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	HEALTH AND I		GIENE G. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	r B	0 1 :				2. DATE OF DEATH MONTH DAY YEAR 11345 P			
pp	1	4. SOCIAL SECURITY NUMBER 217-05-4908	1 □ M 2 🎇 F	In yrs. lest birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day, March 29	TH 8	BIRTHPLACE (State or Foreign Country) Maryland		
, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give s Charlestown Care Centeration of Decement			96. CITY, TOWN C	OR LOCATION OF DE			y of death Linore		
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	STATE 10b. COUNTY			TION T			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	FUNERAL	100. STREET AND NUMBER 3092 Rogers AV	enue		10	H. ZIP CODE 21043			N OF WHAT COUNTRY?		
1215-0020 r attending physician. use as the burlat-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S.YARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			If yes, sp	CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specify	cify Yea or No- 14	as or No 14. RACE — American Indian, Black, White, atc. Specify: White			
₫ ° 0	COMPLETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	S USUAL OCCUPATION work done during mouse retired.)	AL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY							
of the per der	ш	17. FATHER'S NAME (First, Middle, Last) Charles Berlau				18. MOTHER'S NAME (First, Middle, Melden Surname) Elizabeth					
. 9 9 w	TO B	19a. INFORMANT'S NAME (Type/Print) Thelma Fischer		196. MAILING 14 Eva	ans Grove I	and Number or Rural F Road Poquos	Route Number, City Son, Virgi	or Town, State, Zip Co inia 23665	ode)		
IMORE, Page 6 may by al director, page ner must be		20a. METHOD OF DISPOSITION 1 Burlal 2 Commetter 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of carried place) 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of carried place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State									
SALT r death. r death. e funer al.		22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Ave Catonsville Maryland 21228									
filled in flon, or re		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Dehydrafic									
h certificate be executed shading physician and committee prior to burial, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
a and the	MEDICAL C	PERFORMED?						24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
law law ept ept	SICIAN: M	DID TOBACCO USE CONTI			ES NO C		EQ V		1 TYES 2 TONO		
SICIAN: The certificate I the State I, or Item	PHYSIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
DING PHYY After this death with	₽	1 Natural 5 Pending Investigation	JURY WO	YES 2 NO		DESCRIBE HOW INJURY OCCURED OCATION (Street and Number or Rural Route Number,					
OR ATTEN OR ATTEN DIRECTOR: hours after item 28 i	LETED	4 Homicide detarmined City or Town, State)									
Z Z Z =	COMPLET	29a. CERTIFFER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
TO THE HOSPI TO THE FUNEF be filed within IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	ele Vs.	V		29c. LICENSE NUM D34	BER / 05-	29d. DATE S	IGNED (Month, Day, Year)		
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		MAY 0 9 1995	32. REGISTRANS SIGNA	or Revolate	4						



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	1 - STATE	STATE OF MARYL		NT OF HEALTH AND				
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)	CERTIFICA	TE OF DEATH	REG. NO		3. TIME OF DEATH	
	MARGARE	T BAR	Ber			199	AR _	
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday) IF U	NOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	HRTHPLACE (State or Foreign country)	
	061-22-4660-H	1 M 2 PF	7 YRS. MONT	7 7 20 11 20	SCOT 23	27 /	Vew YORK	
E C	90. FACILITY NAME (If not institution, give	- B '	M-5	CITY, TOWN OR LOCATION OF I	DEATH V	9c. COUNTY C	OF DEATH	
5	RESIDENCE OF DECEDENT 104. STATE 10b. COUN			DALLO,		_ ~//	*	
DIRECTOR	MD.	N/A	10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	104. STREET AND NUMBER	7		10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	2214 FLE		:=::	2/2			JSA	
	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 10	13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Maxic 1 YES 2 NO Specify	ean, Puerto Rican, etc.)		RACE — American Indian, Black, Whits, etc.	
	3 Widowed 4 Divorced	20 -2 22 11 22 1		1 125 23 410 3560	ay.		WHITE	
2	15. OECEOENT'S EO (Specify only highest grad	le completed)	(Give kind of work of life. Do NOT use retir	one during most of working	16b. KINO OF BU	SINESS/INOUSTR	RY	
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	0	ENDING	Rect	AURAK	70	
COMPLET	17. FATHER'S NAME (First, Middle, Last)	41			AME (First, Middle, Maiden			
U O	19s. INFORMANT'S NAME (Type/Print)	D'MARA		CATA		EVAN		
2	BARBARA	LINVILLE	196. MAILING ADOI	RESS (Street and Number or Rura	-	-		
	20a. METHOD OF DISPOSITION	206.	PLACE AND DATE OF DIS	PQSITION (Name of	DATÉ 20c. LO	CATION — City o	40 2120611) or Town, State	
	1 Denation 5 Other (Specify)		etery, crematory or other pl	Penstory		ALTO	mD.	
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		22. NAME AND ADDRESS OF F	CE + SO	VS FU	werel Home	
_	maketo	ell Non	K	322 5.	HIGH ST.	BALT	6 21202 M	
- 6	23. PART I. Enter the diseases, or shock, or heart fellure	complications that caused List only one cause on ea	the deeth. Do not en ich line.	nter the mode of dying, su	ch as cerdiec or reep	iratory arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	R	11. 0	,			Onset and Death	
	resulting in desth)	DUE TO (OR AS A	CONSEQUENCE OF):	<u> </u>		76/		
	Sequentially list conditions,	a Fallow	ing righ	+ constru.	and an ten	ecton	29 hours	
	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
2	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
ENTINATION	resulting in deeth) LAST	d						
i	PART II. Other eignificent condition	ons contributing to deeth be	ut not resulting in the	underlying ceuse given in			24b. WERE AUTOPSY FINDINGS	
MEDICA					1 _ YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
3							1 VES 2 NO	
SICIAIN.	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				IN D			
	EXAMINER?	HOSPITAL:		IER:				
	27. MANNER OF DEATH	28s. DATE OF INJURY	28d. OESCRIBE HOW INJURY OCCURED					
	I Netural 5 Pending I Accident Investigation	(Morith, Day, Year)	INJURY	WORK?	28f. LOCATION (Street and Number or Rural Route Number, City or Taym, State)			
	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Speci	At home, tarm, street,	factory, office				
	20. 00000000		N/n					
COMPL	(Check only	SICIAN: To the best of my knowled: On the basis of examination					mele) and manner as state '	
8	29b. SIGNATURE AND TITLE OF CERTIFIE		The state of the s				NED (Month, Day, Year)	
0 8	CH	tu Thomas MI)	29c. LICENSE NU	725	▶ M	les 8 1995	
	30. NAME AND ADDRESS OF PERSON W	10 00101 divis						

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)
MAY 0 9 1995



BALTIMORE, MARYLAND 21215-0020	and in the law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	the continuate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit the State Debt, of Health and Mental Hydiene prior to burial cremation or removal.	arred, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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ALTIN	death. Page	funeral dir	xaminer
B	after	by the	ical e
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30	withir	pletel	ent,
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N OF VITAL RECORDS, P.O. BOX 68760	the de	the function of the state of the attending physician and completely filled in by the function of the state Dent, of Health and Mental Horiene prior to burial, cremation, or removal.	injury
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

			С		ICATE				MENIA	L HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last								2. DATE	OF OEATH	NY.	YEAR 3.	TIME OF DEATH
	THOMAS	MARTIN		_	SHAW					05,1	995		23:59 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. ia			EAR AYS	IF UNDER	24 HRS.	(Monti	OF BIRTH n, Day, Year)	- 1	Country)	ACE (State or Foreign
1 10	159-54-6072 98. FACILITY NAME (If not institution, give		31	YRS.						-25-1		_	NSYLVANIA
- L					96. CITY, TO			ON OF DE	ATH	H 9c. COUNTY OF DEATH			
I E F	9975 HARVEST DR.				1	N/P	-1				FREDERICK		
DIRECTOR	10a. STATE 10b. COUNTY				10c. CITY, TOWN OR LOCATION						10	d. INSIDE CITY	
	MARYLAND FRED	N/A									LIMITS?		
¥	109. STREET AND NUMBER				101, ZIP CODE						10g. CITIZI	EN OF WHA	T COUNTRY?
FUNERAL	9975 HARVEST							702				J.S.	Α.
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	Merried 2 Merried FORCES? 1 YES 2									en, Puerto Rican, etc.) Bis		
	15. OECEDENT'S EO		16a. Di	CEDENT'S	USUAL OCCU	IPATIO	N		165	KIND OF BUS	INCSS (IND)		WHITE
	(Specify only highest grad	College (1-4 or 5+		ive kind of Do NOT u	work done duri	ng mos	st of workin	g	""	KIND OF DO	MVE33/MVD0	otni	
를		2		ELF	EMPLO	OYE	ED		1	LANDL	ORD		
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTH	IER'S NA	ME (First, I	RE (First, Middle, Maiden Surneme)					
l iii	THOMAS M. BUC	R •					MA	RGAI	RET A	. GUN	ITER		
TO B	19e. INFORMANT'S NAME (Type/Print)									er, City or Town		,	
1 II-	ROBINSON-LYTL	E F. HON	ME	36 N	ORTH	SE	EVEN	TH	ST.	INDI	ANA, I	PA. :	15701.
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State												
	LUTHER CHAPEL CEMETERY 5/95 INDIANA, PA.												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO.												
	William Love 11 4905 YORK RD. BALTO., MD. 21212.												
RTIFICATION	shock, or heart failure. List only one cause on each lins. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of):												
E E	resulting in death) LAST												
MEDICAL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							PERFORMED?		CO OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
	25. WAS CASE REFERRED TO MEDICAL	I I I CA			TH (Check only		ONC	EKIAIN	4 [
	EXAMINER? HOSPITAL: OTHER:												
	1 X YES 2 NO	1 Inpatient 2	27. MANNER OF DEATH 269. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED										
		26e. DATE OF	INJURY	28b. TIM	E OF 28	c. INJU	IRY AT		26d, DES	CRIBE HOW IN	JURY OCCU	RED	
PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	26e. DATE OF (Month, De	INJURY	28b. TIM	E OF 28		RK?	NO	0 11		S HOT		CF
BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF (Month, Da	INJURY by Year) 95 INJURY — At ho	28b. TJM INJ	E OF 284	c. INJU WOR	ES 2	NO	281. LOC	ATION (Street e	2 1401	- SE	
ED BY PHYSICIAN:	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	26e. DATE OF (Month, Date of Month), Date of Month,	INJURY by Year) G 5 INJURY — At ho	28b. TIM INJ U U	E OF 284	c. INJU WOR	ES 2	NO	281. LOC	ATION (Street e	S HOT	- SE Rural Route	Number,
ED BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	26e. DATE OF (Month, Da	INJURY y, Year) G 5 INJURY — At ho otc. (Specify) S 1 O SYC	28b. TIM INJ U U me, ferm, s	E OF 286 IURY 1 street, factory,	office	ES 2		281. LOCA CHY 6	ATION (Street e or Town, Stele)	S HOT nd Number of ST DR.	Rural Route FRED	
IPLETED BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	26e. DATE OF (Month, Da 5) 26e. PLACE OF building, G	INJURY y, Year) G S INJURY — At ho atc. (Specify) S L O S The symmyth of the	28b. TIM INJ U W me, ferm, s	E OF URY M 1 street, factory,	office	ES 2	and due	SUC 281. LOCA City of 9975	ATION (Street e or Town, Stere)	S HOT nd Number of ST DR.	Rural Route FRSD	Number,
COMPLETED BY PHYSICIAN:	27. MANNER OF DEATH 1 Neturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	26e. DATE OF (Month, Da 5) 26e. PLACE OF building, of the best of	INJURY y, Year) G S INJURY — At ho atc. (Specify) S L O S The symmyth of the	28b. TIM INJ U W me, ferm, s	E OF URY M 1 street, factory,	c. INJU WOR YI office	ES 2	and due	SUC 281. LOCA City of 9975 to the cau	ATION (Street e or Town, Stere)	ST DR. oner as stated if due to the	Rural Route FR5D	Number,
O BE COMPLETED BY PHYSICIAN:	27. MANNER OF DEATH 1	26e. DATE OF (Month, Da 5) 26e. PLACE OF building, of bui	INJURY y, Year) G S INJURY — At ho etc. (Specify) S (O S M my knowledge, de emination end/or	28b. TIM INJ	E OF URY M 1 street, factory, and at the time, on, in my opini	c. INJU WOR YI office	ES 2	and due od at the (SUC 281. LOCA City of 9975 to the cau	ATION (Street e or Town, Stere)	S WOT ord Number or ST DR. ner as stated d due to the 29d, DATE:	PROFILE COURSE(S) OF SIONED (MO	Number,
TO BE COMPLETED BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) XXMEDICAL EXAMIN	26e. DATE OF (Month, Da 5) 26e. PLACE OF building, or continue of the best of or the basic of ex	INJURY y, Year) G S INJURY — At ho etc. (Specify) S (O S M my knowledge, de emination end/or	28b. TIM INJ	E OF 28- URY M 1 street, factory, and at the time, on, in my opini	c. INJU WOR YI office	and place, with occurrence OCI	and due od at the outside NUM	SUK 281. LOCA 29.75 to the cautime, date BER	ATION (Street e or Rown, Stete) ADQ VG se(e) and man	S North MA	FROM Route FROM Couse(e) en SIONED (Mo	Number, STACK O d manner ee stated. nth, Day, Year)

95 14000

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 95 BREON BULL APRIL 9:36 23 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-43-3990 15 1. M 2 | F HOURS Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NA DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10e STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NA Baltimore Maryland 1 VES 2 INO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21218 USA burial-transit 821 Bonaparte AVenue hours after death, Page 6 may be retained by the hospital or attending physician, ed in by the funeral director, page 5 should be detached for use as the burial-tran 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black. White, etc. If yes, specify Cuben, Mexican, Pr 1 YES 2 NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES ΒY 3 Widowed 4 Divorced Specify: Afro-American COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 165. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired,) Elementary/Secondary (0-12) College (1-4 or 5+) NA NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anthony Bull notified at BE Tyra Moniss 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
821 Bonaparte Avenue Baltimore, Maryland 21218 2 Anthony Bull pe 20s. METHOD OF DISPOSITION

1 Suriel 2 Cremailon 3 Removal from State
4 Donation 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of The Party Party Name of The Party Party Name of The Party 1959) 20c, LOCATION - City or Town, State
Baltimore, Maryland must medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Jeff Miller F/H PC 1639 N. Broadway 21213 filled in by the 21. PARTI. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximete shock, or heart feiture. List only one ceuse on each line. interval Batween 0 IMMEDIATE CAUSE (Final Onset and Death cremation. other traumatic event, the disease or condition_ and completely fi o burial, cremation SUDDEN INFANT DEATH SYNDROME resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSPOUENCE OF)-Hygiene pnor to if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST signed by the atter Health and Mental PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE shows any YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL: OTHER 1 | Inpetient 2 X ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, this c 1) Natural В 1 YES 2 NO After 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, streel, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: / 4 Homicide III item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, end due to the cause(s) end manner es stated. FUNERAL WITHIN 72 TO THE FUNERA TO THE FUNERA THE field within 73 IMPORTANT: II investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) ▶APRIL 25,1995 O.C.M.E. 2 AME AND ADDRESS OF I PLETED CAUSE O DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year)

executed with BOX 68760 OR ATTENDING PHYSICIAN: The law requires that the death certificate be DIVISION OF VITAL RECORDS, P.O.

HOSPITAL

BALTIMORE, MARYLAND 21215-0020

DHMH-15 Rev 1/89

